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ABSTRACT

This report provides background information and summarizes a 1991 seminar on the federal role in coordination, collaboration, and integration strategies for families. A preliminary section identifies highlights of the seminar focusing on: (1) the Project on Improving the Coordination of Federal Public Assistance Programs; (2) key findings and recommendations of the National Commission on Employment Policy; (3) coordination between the three largest federally funded programs for at-risk youth (Chapter 1, Individuals with Disabilities Education Act, and the Bilingual Education Act); and (4) the role of the American Enterprise Institute. The major body of the report presents information on the need for reform. the key objectives and tools of services reform, and history of services integration. A major section describes current cooperative initiatives in the following areas: employment, training, and public assistance programs; seriously troubled children and families' services; education; child care and early childhood programs; and health services for children and families. Further sections examine what the federal role in service integration should be, issues and questions for study and debate, and pending federal legislation. The report concludes with brief descriptions of 11 organizational resources and a list of 40 references. (DB)

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Coordination, Collaboration, Integration: Strategies for Serving Families More Effectively

Part One: The Federal Role

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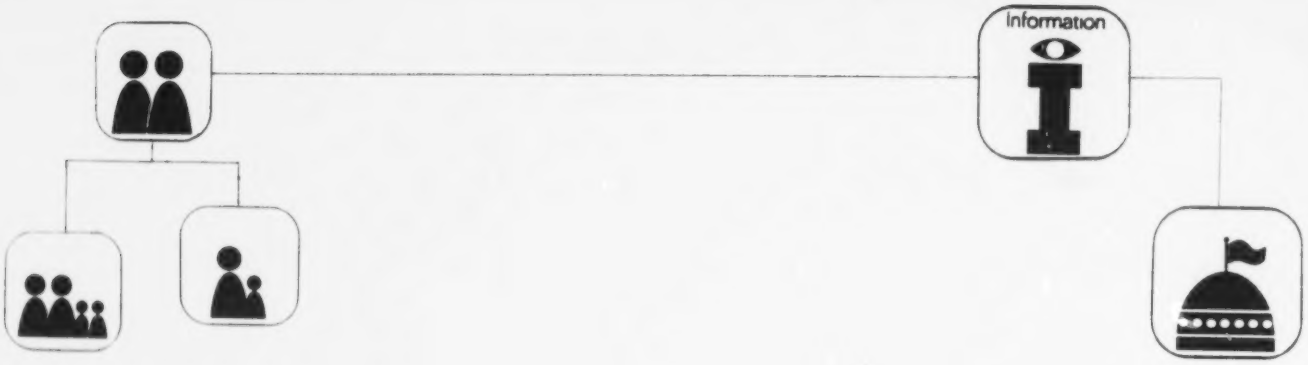

Coordination, Collaboration, Integration: Strategies for Serving Families More Effectively

Part One: The Federal Role

September 27, 1991, Dirksen Senate Office Building, Rm. 366

Panelists: **Josie Thomas**, family networking coordinator, Association for the Care of Children's Health
Neal Zank, associate director, National Commission For Employment Policy
Cynthia Brown, director, Resource Center on Education Equity, Council of Chief State School Officers
Douglas Besharov, resident scholar, American Enterprise Institute

Moderator: **Theodora Ooms**, director, Family Impact Seminar

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COORDINATION, COLLABORATION, INTEGRATION: STRATEGIES FOR SERVING FAMILIES MORE EFFECTIVELY

Part One: The Federal Role

Background Briefing Report
and Meeting Highlights
by
Theodora Ooms and Todd Owen

This policy seminar is one in a series of monthly seminars for policy staff titled, *Family Centered Social Policy: The Emerging Agenda*, conducted by the **Family Impact Seminar**, American Association for Marriage and Family Therapy, Research and Education Foundation, 1100 Seventeenth Street, N.W., The Tenth Floor, Washington, D.C. 20036, 202/467-5114.

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Family Resource Coalition (FRC)
Family Service America (FSA)
National Council on Family Relations (NCFR)

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Coordination, Collaboration, Integration:

Strategies for Serving Families More Effectively

Part One: The Federal Role

Highlights of the seminar meeting held on September 27, 1991, Dirksen Senate Office Building, Rm. 366. (A supplement to the background briefing report.)

In her opening remarks **Theodora Ooms** said that this was the first seminar in a series of five aimed at demystifying the current new buzz words "coordination, collaboration and service integration." Today's seminar was designed to provide an overview of the scope of these reform activities across many program sectors and to focus especially on the federal role. The first speaker, Josie Thomas, would help us understand what the problems are from the consumers' perspective; telling us about what families experience when trying to obtain the multiple services they need, in this case for their disabled or chronically ill child.

Josie Thomas is mother of three children---one of them with disabilities---a grandmother, a former foster parent, and is currently employed as the family networking coordinator at the Association for the Care of Children's Health.

Three families' experience. Thomas opened with the stories of three families who are typical of many other families around the country. "My friend's husband left her last week," began Thomas. "After ten years of struggling to keep their twin children who have multiple, life threatening disabling conditions alive, coping with frequent trips to the emergency room when a son couldn't breathe, arguing (and losing) with their health insurance company to keep the nursing care they desperately needed at night so they could sleep or spend an evening alone together or with friends, and fighting for the right to have their children attend their community school with their non-disabled peers---this couple's marriage finally disintegrated."

Thomas explained that these parents are a well-educated, motivated, articulate, two-income, middle-class family who are too rich to qualify for any support programs and are too poor to be able to afford the care they need. They are heavily in debt because of their children's incredible medical expenses that their health insurance will not cover. Neither of these parents have extended family available to support them.

Two evenings ago the son turned blue again. It used to take two of them to hold him down to bag him and administer oxygen. The mother struggled with him alone until he lost consciousness and then she was able to administer the oxygen he needed. Thomas added, "the irony is that now that my friend's husband is gone, the family will probably qualify for several programs."

The second family involved a young working mother who had called Thomas asking for information about the availability in her community of early intervention services for her baby and family. Her 5-month old son has multiple conditions that include the inability to move or lift his head and severe feeding problems. Their health insurance was not willing to cover the costs of the therapies that would help this baby eat better and begin moving. Their physician did not know much about community services and was not able to make any referrals. This family is extremely isolated.

However, with some good fortune this mother had found a special child care program that provides care to babies with disabling conditions---a rarity in most places. She then met with the people in the school system who are responsible for providing these services. After this meeting she called Thomas in tears of frustration. Her baby was clearly eligible for early intervention services such as occupational therapy and/or physical therapy. The problem was that the school system refused to provide those services to her child and family at the day care site so that the child's primary care giver during the day could be part of the intervention and be able to continue the activities during the day. The school also refused to provide services at home so that the family could be part of the intervention.

All the school could offer was a center-based program at a school some distance from the child care center. They wanted to come and pick up the 5-month old baby on his own in a school bus and take him to the school for his treatment!

Thomas commented that this baby and family do **not** need a program where the baby is treated in isolation. They need services that are coordinated between the physician, the early interventionist, the therapists, the child care provider, the health insurance provider, and the family. They need services that will respect the family's need to be and grow as a family. Instead they must spend their time fighting a disorganized and inflexible system.

The third family story Thomas presented was a deaf couple who just had a baby born with heart problems and in need of several surgeries. The father's employer offers family health insurance at $250 a month but he cannot afford this, so his family does not have health insurance.

He recently applied for Medicaid. Because he does not have a car, he had to take two buses to get to the Medicaid office which was closed when he arrived. He could not call them because he is deaf and they do not have a TTY. He had to take unpaid time off to return when they were open only to find out that he and his family are ineligible.

As these examples illustrate, families caring for children with special health care needs face many challenges, Thomas said. They confront complex, even frightening emotions, live with uncertainty and many illnesses, cope with multiple health encounters. If they are poor families of color this isolation is especially acute as it is compounded by racism and institutionalized disempowerment. Many need resources and services that are not available. The services that do exist are often of poor quality and inaccessible because of location or hours of operation.

Parent support groups. In the absence of such services, parent groups and networks have emerged as a potent source of emotional support and empowerment for families of children with special needs. Many parent networks and groups have taken on the role of helping families coordinate services for their children. (Note: Local support groups in the DC area include Sick Kids Need Involved People (SKIP) and a number of disability specific groups such as the United Cerebral Palsy Association, etc.) These groups often act as referral sources, case managers, and advocates for families. In addition each state now has a federally funded Parent Training and Information Center. These centers help families with information, referral, and advocacy for special education. Unfortunately these groups and networks do not exist everywhere and families continue to be isolated and without needed services.

As a final example Thomas concluded by reading a letter from a woman saying she and her husband were having an increasingly difficult time providing the proper care for their growing disabled son, now 15 years old. In particular they were in need of funds to remodel and furnish their son's bedroom and bathroom with specially designed equipment in order to be able to lift him and bathe him. She feared that they were near a point where her son will be too large for them to care for him and without the proper equipment in their home, they will have to place him in an institution. They have searched everywhere for such funding but reached a dead end.

Thomas closed by saying that what this and other families like it desperately need are services that support the family in their natural caregiving role and that are:

---**accessible,** not unavailable, unaffordable, and unreachable;
---**family-centered,** not inflexible and bureaucratic;
---**coordinated,** not fragmented and disorganized.

Neal Zank, the second panelist, is associate director of the National Commission on Employment Policy. Zank began by briefly describing the National Commission (see page 32). He said that about two years ago the Commission started focusing in depth on the eligibility and criteria issues associated with employment training programs. They quickly found they had to also look at the broad array of public assistance programs to fully assess the problems.

Thus they launched the **Project on Improving the Coordination of Federal Public Assistance Programs.** In this project they have heard the views of over 200 people from all levels involved in every aspect of the issue, from policymaking to program implementation and service delivery. They have sponsored three conferences around the country, held hearings, gone on site visits, and conducted research.

Zank then summarized the Commission's key findings in the Coordination project:

---They found 75 federal programs providing assistance to economically disadvantaged people. This array of programs involved $200 billion in federal expenditures and includes AFDC, Medicaid, food, housing, employment, education, and training programs.

---The multitude of regulations, procedures, documentation requirements, and terminologies used in these programs have contributed to a very uncoordinated system which everyone finds extremely frustrating to deal with.

---Barriers to coordinated services include different funding formulas, administrative provisions, eligibility criteria, planning and operating tables, definitions, and much bureaucratic territoriality and conflicting regulations.

---At the state and local level, people clearly feel the biggest single barrier they face is the federal bureaucracy. The number of federal agencies, organizations, and committees involved in the administration or oversight of the programs is mind boggling. They identified over 40 Members of Congress who either chaired or were ranking members of a committee related to public assistance programs.

---At the federal level, people in Washington felt the problem was everywhere else or denied there was a problem! Neither the representatives from the Congress nor the Administration who attended their meetings appeared open to hearing recommendations for reorganization or restructuring at the federal level.

After describing the variety of perspectives represented at their three conferences, Zank then addressed the Commission's recommendations, noting that they would be formally issued the following week. There was widespread agreement that the most important recommendation concerned national leadership. People at the local level felt that little could be accomplished unless the President and Congress were out front leading the way.

The Commission recommended that the President:

---Exert leadership and give direction to the appropriate departments and agencies to encourage them to undertake actions to improve coordination.

---Expand the authority and mission of the White House Economic Empowerment Task Force (which last year replaced the Low Income Opportunity Board) to resolve problems that affect the design and implementation of federal public assistance programs.

---Direct the agencies that administer public assistance programs to develop a common framework for streamlining eligibility requirements, formulating standard definitions and poverty measures, and easing administrative and documentation requirements. Zank also mentioned the idea of a federal technology grants program to help states develop software to enhance program coordination.

---Combine the primary programs that provide employment and training services to the economically disadvantaged (JOBS, JTPA, and Food Stamps Employment and Training Program) into one agency operating under the same policy leadership and direction.

The Commission recommended that Congress:

---Assign responsibility for legislation and oversight of public assistance programs to a single committee in each chamber. Or if this is not possible, to form a Joint Committee on Public Assistance, based on the model of the Joint Committee on Taxation.

---Work with the Executive branch agencies to develop the framework for streamlining eligibility requirements, poverty measures, and easing administrative and documentation requirements.

---Enact legislation to establish human resource or investment councils at the state level to foster more coordinated approaches in such key functions as planning, operation, and oversight. According to Zank, in some states where this has happened, such as New Jersey, they have gotten a handle on employment training programs and have actually seen a reduction in administrative costs.

---Require that an economic, fiscal, and institutional analysis be conducted for each congressionally proposed reform of public assistance programs.

Zank noted that they were under no illusions---these are very tough recommendations to get implemented. He expects lots of opposition from agencies, Congress, and interest groups. He concluded by stating that the Commission hopes that these recommendations will serve as a lightening rod for some of the other groups who have recently begun to work on this issue, such as AEI and the Welfare Simplification Committee set up by Congress last year. There are immediate actions that can be taken before waiting for the next election.

The next speaker was **Cynthia Brown,** formerly Assistant Secretary for Civil Rights in the Department of Education, and current director of the Resource Center on Educational Equity,

Council of Chief State School Officers (CCSSO). Before addressing the issue of coordination within the federal education sector she began with a brief summary of the key features of the three largest federally funded programs for at-risk youth, focusing only on kindergarten through twelfth grade.

- **Chapter 1** of the Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 is the largest federal non-loan education program ($6.2 billion in FY '91). Chapter 1 services are provided in 75% of the nation's elementary schools and 90% of the school districts and schools have considerable flexibility in how they spend the monies. It is a program for educationally disadvantaged, i.e. low-achieving, children in schools with high proportions of low-income students. In Brown's view two of its main problems are that more non-poor than poor children receive services and that schools that are successful in raising achievement levels are penalized by receiving less funding.

- **Individuals with Disabilities Education Act (IDEA)** is a quasi-civil rights law that requires states to guarantee that every disabled child will receive a free appropriate education before the state can receive any federal funds. However, the amount of federal funding is less than 10% of the excess costs above the costs of educating a regular student ($2 billion in FY '91). Every state has its own special education program, completely integrated with the federal program.

  Brown noted that many of the students in special education look a lot like the educationally disadvantaged kids in Chapter 1 programs. Many people are surprised to learn that under 6% are physically disabled and 20% have mild or serious retardation or severe emotional/psychological problems. But about 75% of all special education students have mild learning disabilities or speech and language impairments.

- **The Bilingual Education Act** is a small federal, non-entitlement program providing assistance to limited English proficient (LEP) students ($200 million in FY '91). Brown said that 8 or 9 times as many children are served in state and locally funded programs. School districts apply for funds directly from the U.S. Department of Education. It is not a state administered program which makes coordination with these two other programs even more difficult. (For more information see CCSSO, 1991.)

While each of these programs has brought much benefit to the children they serve, Brown said there are many problems with regard to their integration and coordination with each other. All three of these are categorical programs, each with its own set of rules and regulations. Problems arise especially where all three programs operate in the same school and where one child is potentially eligible for services under two or all three programs.

Children served in isolation. In all three programs restrictive requirements have led to the provision of services and special education programs in segregated, isolated settings where children are "pulled out" of the regular classroom. She said, "instead of this isolation, many educators, including myself and my organization, advocate extra support and help for most of these students in the regular classroom." According to Brown there are numerous explanations for this high degree of isolation, including administrative requirements, separate certification for special education teachers, and state financing systems which reward isolated classroom placement.

Uncoordinated services. Brown then gave some examples of the coordination problems she and her staff learned about from visits made to schools serving low-income and other at-risk students. They found that most schools had been unable to use federal categorical programs to develop and implement flexible, regular classroom-based services to meet the range of their students' needs. Brown said that 70% of children with disabilities receive instruction outside of

the regular classroom. Importantly, Brown gave examples of how children in all three of these program categories can overlap, and yet are often prevented from accessing services from the other programs.

---IDEA regulations require that students be diagnosed to be eligible for special education services. However, many experts agree that distinguishing between mildly learning disabled students---which are the vast majority of learning disabled children---and educationally disadvantaged students eligible for Chapter 1 services is virtually impossible.

---LEP students often have special needs that fall under the jurisdiction of multiple categorical programs, but these services are rarely coordinated. Some school districts even prohibit a student from receiving assistance from more than one categorical program. A recent study of Chapter 1 services to LEP students noted that 5% of all districts studied automatically excluded LEP students. Further, federal statutory and regulatory barriers prevent educators from developing interventions that would enable LEP students to benefit from Chapter 1 programs in the area of English language development.

Brown concluded by mentioning several more problems arising from the lack of program integration and then briefly commented on what can be done about them. Brown noted that because of the constituency politics surrounding these programs and the relative lack of priority given to these issues on a very full national education reform agenda these problems won't be easily solved. "I believe these three programs should and can be combined in a way that entitles all disabled, LEP, and low-achieving students in schools with high, not low, proportions of low-income students to extra educational services needed for them to achieve the high education standards our nation's leaders are calling for."

Brown mentioned that a two-year, foundation supported **Commission on Chapter 1** made up of researchers, child advocates, and education practitioners is now meeting regularly to recommend major improvements in Chapter 1 when it is reauthorized in 1993. This Commission is housed at the Council of Chief State School Officers and is staffed by Brown and her Council colleagues.

Doug Besharov, the fourth panelist, is a resident scholar at the American Enterprise Institute (AEI), and director of the new **AEI/White House Working Seminar on Integrated Services for Children and Families.** Besharov began by explaining why AEI is prepared to spend almost two years on this issue.

"My sense from traveling around the country is that this is a grassroots issue. People are very concerned about the geometric proliferation of categorical programs in the last few years. If something is going to happen to change this situation it will be because local service providers are chafing under the rules and regulations of these programs in many different program areas."

Besharov said another reason for supporting service integration is that at least for the next year or two we can expect the budget agreement to hold sufficiently so that there won't be any major new funding initiatives. "When you can't increase services dramatically, you make the most out of the funds you have." The present financial situation thus "focuses the mind" on current programs and how they can be improved.

What is the rationale for integration? Besharov asked. Not everyone is in favor of the idea. Categorical programs clearly generate separate amounts of interest, energy, and publicity and there is a theory that for these reasons they also generate more money overall for services than do non-categorical programs.

On the other side of the argument is the concern that the proliferation of these programs makes it impossible for the managers (local, state, and federal) to see the forest from the trees. Besharov said he spends a lot of time talking to local administrators and is amazed by the proportion of their time and energy that is spent on tiny little programs. There is almost as much time spent briefing an Assistant Secretary on a $15 million program as on a $2 billion program! And policymakers spend more time worrying about whether they have met eligibility requirements than whether they in fact reduced the level of child abuse that year. In determining whether or not decategorization makes sense, Besharov said, one must balance the possibility of lower levels of funding with the gains from a more strategic focus on real results for children and families. The answer, he continued, may depend on the program or type of issue.

AEI's Working Seminar on Integration. The Working Seminar is loosely modelled on AEI's seminar on welfare reform of four years ago. Its members include high ranking representatives from the Administration and Congress, and other experts. The Seminar will meet for about a year, commission papers, and conduct some data analysis. Sometime just after Election Day 1992 they will issue a report.

The seminar will look at a series of categorical issues separately, then together. One major set of programs they will examine is **child care**. Over the last few years several new child care programs have been enacted, together with a large infusion of new funding, each with its own regulations, standards, and administrative agencies. This all makes life very difficult for people at the local level who are simply trying to help low-income people get the child care they need. The second major set of programs they will examine closely is **child welfare**. In this field again there is an incredible array of categorical programs, including several demonstration grant programs for under $10 million a year. The areas of health care and education/job training will also be explored.

Cross-cutting issues. Besharov then said that the Seminar will also be wrestling with several cross cutting issues.

---The first is whether politically it would not be more feasible, as the NGA's recent report on block granting has recommended, to restrict the programs to be decategorized to those within the jurisdiction of one congressional committee, or even sub-committee.

---The second is the issue of budget neutrality which many believe should be the goal for services integration. The problem here is that there are so many different definitions of poverty and eligibility across states and programs. If these were to be standardized through decategorization you face the dilemma of either raising the level of service provision to the most generous levels, for example to families with incomes at 185% of the poverty level---which would bust the budget---or keeping it at a lower level which would deny services to many families who are presently receiving them. This would be politically unacceptable.

Besharov spoke about the importance of building services integration strategy on a foundation of **strategic data and research.** As an example he presented some longitudinal statewide data from Illinois which showed that children who were removed from their homes and placed in group (congregate) care were at much higher risk of psychiatric hospitalization later on than children who remained at home or were placed in foster family care. This kind of social mapping Besharov believes deepens our understanding of how caseloads overlap between systems---a necessary first step to services integration.

Besharov also stressed the importance of the geographical dimensions of social needs and services. He illustrated this point with a map of Manhattan showing how infant foster care placements were concentrated in the northern section of the borough and yet the child welfare services agencies were concentrated in the south. Besharov commented that this kind of data is the exception; there are no incentives in present systems to collect and analyze data in these ways.

Finally, he mentioned that the Seminar would not be making any recommendations for major reorganizations of basic services. This was too complex a topic and not enough was known about it. But they were very interested in exploring how much support there would be for enactment of a broad waiver program for states to allow them to custom design their own integration packages. "I believe that we only move forward in social policy one small step at a time," Besharov concluded.

POINTS MADE DURING DISCUSSION

- A Senate committee staffer suggested that the problem was that Congress didn't really trust the local folks so they try to maintain local accountability through narrow categorical programs. Hadn't we better develop improved accountability through deciding on the appropriate outcome measures? Most of these programs don't have outcome measures that Congress can believe in.

  Zank responded that it is unfortunate that people in Washington don't trust those in the states. Yet he noted that the Jobs Training Partnership Act has performance standards and is as distrusted as any other program. Often there are fights against putting performance standards in programs.

  Besharov commented that in the 60s and 70s there was great distrust of states, some of which was driven by civil rights issues. And through the mid-1970s, in many areas of social welfare the federal government was just smarter than the states. However, that has all turned around; on any one issue there are now 10-15 states who are wiser than the federal government. He agreed with the staffer's comment but noted that many more members of Congress understand that the Feds have relatively little to offer states nowadays except for cash.

- The first speaker returned to his point that Congress and the Administration are trying to micromanage programs by creating numerous little requirements. They do this because there is no way of getting accountability. He repeated his question about what effort was being invested in developing good outcome measures to deal with this problem?

  Brown replied that the field of education is a little different and while there is work being done to improve outcome measures, there are already many more outcome measures in education. The gaps between the performance of white and minority kids has closed by 50% since the enactment of these programs---that's good outcome news. The problem is that what we want in outcomes has changed a great deal. We want much higher performance among all kids, and teachers who know how to produce the outcomes, than we know how to measure. Measuring outcomes is important but it is not the final answer.

  Ooms added that while education, welfare, and jobs training may have established some clear outcomes, it was her sense that there is much less agreement in the field of child welfare, mental health, etc. on what desirable program outcomes are.

  Besharov said that focusing on outcomes is obviously a good idea but there are some difficult technical, moral, and political problems. The technical problems involve comparing outcomes from very diverse states and localities such as comparing Kansas to New York or Upstate New York to New York City. The outcome measures must also measure the starting point---in order to calculate the value added---because in some locations it is easier to make a difference than in others. It is for example, tougher to break your drug habit if you live in upper Manhattan than in suburban Maryland.

The moral issue is this: What do you do if New York City consistently fails to make a difference in the lives of its poor children? Do you cut off funds? That is the other problem with outcome measures. You can't penalize the children because New York City can't get its act together.

- A staff member from the National Governor's Association asked how the AEI White House Working Seminar differs from the White House Low Income Opportunity Board, which she understood was designed to accomplish similar objectives but so far hadn't gotten anywhere. **Besharov** replied that the AEI group is a quite separate effort and a little different in that it includes an equal representation of Congressional members, Administration officials, and outsiders. Also at AEI they are engaging in an elaborate research agenda to demonstrate some of the connections between problems and programs. But he hoped the efforts of both projects would be complementary.

- In response to a question about state and local systemic problems, **Zank** said they had sensed there was little interest and leadership from Governors on these issues.

- A gentleman from the Department of Education thought that the proliferation of committees and individuals responsible for these programs in Congress will perpetuate this categorized system forever unless that system is changed.

  Zank added that at their first seminar a congressional staffer was asked if they believed that their system was adequately addressing these problems or if they would recommend changes to improve it. The staffer responded that "no, they aren't adequately addressing these problems and no, they aren't going to change." (In fact the Commission did make recommendations for changes in the Congress.) This is a big problem. Unless you keep raising the issue to Congress they will never address it. And it must be raised from the grassroots, state, and local levels. On this point, **Besharov** added that he believed that Members of Congress were more interested in reforms than staff because they were in closer touch with constituent complaints.

- A participant from the Office of Planning and Evaluation in HHS remarked that the U.S. $200 billion system of public services is "muscle bound by its own goodwill." Wouldn't it be better to shift to the "new paradigm" and transfer empowerment to the people, for example through a voucher system?

  Brown responded that she agreed with him except for his recommendation about the vouchers. The organization of Congress is a problem but it is not the fundamental problem. The problem has to do with the bureaucracy and the constituency groups lobbying on these bills. They aren't organizations of parents and families. They are organizations of professionals who deliver these services. When you start changing the way services are delivered it effects the way professionals do their work and how they are certified and educated. With the vouchers, there isn't going to be anywhere people can go to buy these services in an integrated manner until the way services are delivered is changed---not just in legislation but also in certification requirements and ways we use them. The teachers and administrators of these various education programs don't want them combined because it is going to change the way they do their job. And they are the most important lobbyists on this issue.

COORDINATION, COLLABORATION, INTEGRATION:

STRATEGIES FOR SERVING FAMILIES MORE EFFECTIVELY

Part I The Federal Role

INTRODUCTION

Services for children and families are coming under increasingly critical scrutiny. This era of tight budgets has constrained expansion of services, thus, issues of quality and effectiveness are becoming more important. Many are convinced that the basic design and organization of the present system of categorical services is ineffective, outdated and needs substantial, if not radical, reform. Services reform is especially urgent for those children and families who are poor and/or have multiple needs and absorb such a large portion of federal and state budgets. For them, according to the report of the National Commission on Children, "the present system of services and supports is totally inadequate" (1991, p. 312).

The many problems that plague the current categorical services system are not new and they have multiple roots. For many years state and local organizations, some with federal encouragement, have experimented with new forms of organization and new service delivery strategies to counter the fragmentation. This experimentation is picking up steam and is quite suddenly attracting a great deal of national attention. All over the United States the policy and human service community is using the new buzz words of "services integration," "collaboration," and "coordination."

Ironically, but predictably, these reform efforts themselves are highly uncoordinated and fragmented. They are bubbling up in many communities and in every major service sector. Some are very ambitious and involve statewide systems reform. While reformers appear to be talking the same language, upon closer look there is little consensus on goals or definitions of terms. Lessons from the past are in danger of being ignored. Strategies and tools are being continuously reinvented. Amidst all the enthusiasm the many obstacles that lie ahead are often underestimated.

Several attempts are underway to try to bring some coherence and a greater degree of understanding to this emerging field, but face an enormous challenge since so much is happening so fast. Most of the efforts to date describe and catalog the varied new approaches and program demonstrations, identify common principles and components, and analyze their strengths and weaknesses. Some are beginning to provide technical assistance.

This report is the first in a series of five planned to explore this extremely complex and rapidly developing new child and family services reform movement. Future seminars and briefing reports will focus on reform initiatives at state and local levels examining in some depth the financing, organizational, and service delivery tools and strategies being used. In addition, two seminars are planned to consider implications of these reforms for staff training and program monitoring and evaluation.

This first report aims to be an introduction to this broad topic, presenting a broad brush overview of what is happening, where and why. Specifically this report will:

---Clarify some of the service problems that these reforms are designed to remedy from the perspective of the families who receive them.

---Describe the different types of strategies being used and proposed to make these services become better utilized and more efficient, effective, and "family-friendly."

---Discuss the several objectives of these reforms and different perspectives on how extensive and radical they should be.

---Summarize the history of earlier efforts at services integration.

---Show how these problems are being defined and approached in the major program areas: employment, training, and public assistance; child welfare, mental health, and other children's services; preschool and child care programs; and health and education.

---Outline the many different ways in which the federal government can play a role in these reforms.

---Present some of the key issues and questions that need to be studied and debated as these developments move forward.

---Finally, we provide a listing of current national legislation and organizational initiatives in the public and private sector related to integrated services reform.

Note: While the focus of this series is on services to families with children, especially for the most poor, many of the issues of integration, collaboration, and coordination apply to any individual or family needing services at all life stages, especially those with multiple and chronic needs. Hence we hope in future reports to occasionally draw on similar approaches being tried in programs serving adults, the elderly and their families, and the homeless.

WHY IS REFORM NEEDED?

(Sources: Institute of Medicine, 1982; Keniston, 1977; National Commission on Children, 1991)

The self-sufficient family is a myth. All families need help raising their children. They all use services provided by the formal education and health care systems, use babysitting and child care services, as well as help from family, friends, neighbors, and community-based organizations. In addition, most families need assistance at one time or another from the social service, legal, mental health, and other sectors when they experience special needs or crises such as divorce, temporary unemployment, a child's school difficulty, a teenager's problem behavior or a serious accident or illness and so forth.

A few families need intensive assistance from multiple services, often over a long period and especially if they are very poor and/or a member(s) of their families has a serious, chronic disability, illness or behavioral problem (e.g. alcoholism). It is this third group that is the special concern and focus of integrated services since these families are a special responsibility of the public sector and they currently absorb a very large share of the direct program budget. However, the underlying need for coordinated, holistic, and integrated services is shared by **all** families.

Families as consumers of services. Families with at least some economic resources and other types of support normally have some positive experiences with the human service sector and are usually able to get the help they need. However, this is often in spite of the many practical difficulties they encounter in the process of obtaining help.
Even middle class families often experience monumental frustrations and barriers in finding and paying for appropriate services for themselves and their children. Most often it is one parent, the

Even middle class families often experience monumental frustrations and barriers in finding and paying for appropriate services for themselves and their children. Most often it is one parent, the mother, who plays the pivotal role in helping the family get the services they need and functions as coordinator, case-manager, and mediator. Juggling child care and school schedules with work and household responsibilities in addition to making the necessary school and health care appointments places a constant strain on parents. Service providers' hours are highly inconvenient and usually require taking time off from work. Processing insurance reimbursement forms is time consuming and complicated.

Further, the current services system is highly professionalized and specialized, placing the parent in the non-expert role. Too often parents feel patronized. Their own expertise and wishes are ignored or misunderstood. This was well expressed in the report of the Carnegie Council on Children in 1977,

"The parent today is usually a coordinator without voice or authority, a maestro trying to conduct an orchestra of players who have never met and who play from a multitude of different scores, each in a notation the conductor cannot read. If parents are frustrated, it is no wonder: for although they have the responsibility for their children's lives, they hardly ever have the voice, the authority, or the power to make others listen to them" (Keniston, 1977, p. 18).

Another problem with the highly specialized nature of many services is that service providers approach a child or adult with a narrow focus and too often miss or ignore problems or needs that are interrelated. Finally, services are usually targeted on either the individual child or parent. Few seek to assess the wellbeing of the family as a whole or the affect of one member upon another. For example, typically neither school personnel nor health care professionals take into account that a parent's serious mental or physical illness or marital conflict has an impact on the child's learning problem or teenager's failure to attend school, depression or substance abuse, or alternatively that the child's problem has an effect on the parent's. Service providers seldom communicate with one another.

Families whose children have special needs. When a baby is born with serious disabilities, or an older child develops a learning or emotional problem, or a teenager gets heavily involved with drugs the family will experience escalating difficulties in obtaining services, difficulties which stretch far out into the future. Children with special health care needs require services provided by professionals from many different disciplines who typically do not work as a team. Many teenagers engaging in destructive behaviors similarly require multiple services from different providers. In addition there is often a mismatch between the type of service available and the service needed by a particular child. Children with two or more categorical needs---e.g. a Spanish speaking child with emotional problems---may only be able to receive services designed to address one of these needs not both. Or other children with more than one diagnostic label may not be able to get any appropriate services at all because "dual diagnosed" children are not admitted to many programs.

Another common problem faced by families whose children have special service needs is that the rules governing funding (whether public or private) often only pay for the most institutional, expensive type of service for their child which is not usually what the child requires. Outpatient, or home-based services are typically not "covered" services. Again many of these special services are only available to the individual "diagnosed" child, not for the family. Services that provide parents with the information, education, counseling, therapy, and ongoing home-based support needed to care for the child or teenager are usually not reimbursable. Too often a family has to try to squeeze its needs into predefined categories of existing services rather than the services meeting families' needs.

These difficulties multiply for families in which there is only one parent, for families where there are few relatives, friends or neighbors to provide assistance and support, and for families who do not speak the language and are unfamiliar with the social culture.

Special problems of poor families. The problems already outlined are compounded and take on several unique dimensions for those families who are poor. Low-income working families are particularly vulnerable as they frequently have little or no health insurance, are not eligible for public subsidies, and yet do not have enough income to pay for services themselves.

In addition to the services needed by all families, many poor families are dependent upon a wide range of categorical public assistance programs providing income or in-kind support (e.g. AFDC, Food stamps, Medicaid, subsidized housing, child care, etc.) administered by different agencies often based in different locations. Poor families are more likely to have multiple problems and need multiple services. It is these multi-problem families whose children are deemed to be at "most risk" of school failure and drop out, and welfare dependency. It is these families who are the primary targets of most of the current integrated services projects. Some of the experiences poor families have as consumers of services are as follows.

---Typically a poor parent will have to go to several different offices to establish that she is poor and eligible for services, and she will have to do this several times, filling out different forms each time. Each program has different definitions of who qualifies for assistance and rules about how to count and document income, assets, etc.

---Many poor families are so inhibited by these regulatory, physical, cultural and other barriers that they do not seek out the services to which they are entitled. This may be especially true for families who do not speak English.

---Once in receipt of assistance the parent is expected to inform the agency of any change in family circumstances, income or receipt of other benefits which may affect their eligibility for the service or level of benefit. If a parent goes in and out of the labor force, for example, their family's eligibility for assistance may change many times a year.

---Since the Family Support Act of 1988, parents receiving AFDC have to fulfill certain requirements such as enrolling in an educational, training, or work related activity, or sometimes in a drug treatment program. These requirements entail finding suitable, convenient child care which often doesn't exist---adding to the logistical complexities of their lives.

---Poor families seldom have access to convenient transportation which makes it harder for them to get to services. They are also more likely to face problems dealing with their environment such as their housing and the neighborhood.

---Poor families typically have no source of regular, preventive medical care and usually only seek health care in crisis at an emergency room or public health clinic where they are unlikely to see the same professional each time.

---It is not uncommon for such "at-risk" families with several children to have between 4-8 "workers" assigned to them from different agencies such as the AFDC worker, visiting nurse, probation officer, drug abuse counselor, child protective services worker, truant officer, in addition to the children's teachers, etc. Each one of these is only concerned with a segment of what they see as a dysfunctional family. Again these workers seldom communicate with each other and none of them are charged with the responsibility to assess the families' needs or strengths or work for the families' wellbeing as a whole.

---Finally, in their face to face encounters with staff of public agencies, poor families are much more likely to meet staff with little experience and training, who have enormously high caseloads, and whose job descriptions are very narrow (e.g. eligibility worker). High staff turnover in public agencies means there is little opportunity for the worker and client to get to know each other and build a relationship. These front line workers have very little time to spend either explaining the program, assessing clients' needs, or making referrals. Poor families are even more likely than middle class families to encounter agency staff who give them very little information, nor are they accorded respect or given choice or control over the services they receive.

Faced with this litany of barriers and problems is it any surprise that tax payers are concerned that the services they fund are not meeting families' needs and thereby so often fail to achieve their goals? The miracle is that some families do become adept at negotiating these system mazes and do manage to get the benefits to which they are entitled and use them to improve their children's and families' lives.

These problems and barriers experienced by families seeking help have a host of causes. They are the combined result of the way services are designed, administered, implemented, and monitored. In this emerging reform movement, various initiatives target only certain aspects of these problems. But taken as a whole the service integration movement targets, and hopes to improve, almost every one of these problems we have just described.

WHAT ARE THE KEY OBJECTIVES AND TOOLS OF SERVICES REFORM?

(Sources: Bane and Lusi, 1991; Institute of Medicine, 1982; Jennings and Zank, eds., forthcoming; Maternal and Child Health Bureau, 1991; Morrill 2/90, 5/91; Weissbourd, 1991)

Coordination, collaboration, and services integration are strategic means to accomplish various ends. Some use the terms coordination, collaboration, and integration as if they were interchangeable. Others find they have quite distinct meanings. For convenience, in this report we will occasionally use the term "services integration" to serve as the shorthand umbrella term for all these related strategies. Otherwise, reflecting the confusion in the field, we use the terms coordination and collaboration somewhat loosely.

What then are the key objectives of this broad services reform movement and what specific strategies and tools are used or proposed to accomplish them? There are three principal goals threading through all the various materials and discussions about integrated services that we reviewed for this report.

1. Improving program efficiency

A major goal of services integration is to reduce inefficiency, waste, and duplication through improved coordination of the array of categorical services targeted on one broad population group. Although this goal is basically designed to reduce management costs, if achieved it would also result in easier access and less hassle for the families served.

This goal can only be achieved through sustained collaborative effort of key stakeholders in both the executive and legislative branches. Collaboration needs to focus around several common goals: to resolve eligibility conflicts between programs; to simplify, centralize, and computerize intake procedures; and to standardize program definitions and performance standards, data requirements, and reporting timetables across programs.

In the short run this kind of coordinated effort takes many hours of work and generally needs additional modest resources. However, if it succeeds and such simplification measures were taken it is claimed that considerable cost savings will result. These savings can then be ploughed back into direct services. (For example, less staff time would be spent on paperwork.) At the service delivery level this efficiency goal can be considerably aided by co-location of services, a single point of intake, computerized intake procedures, case tracking, and referral mechanisms.

Although such changes are not designed to expand the eligible population they are intended to increase utilization of services. And this will increase the costs. This is presumably one reason why it has been so hard to make these kinds of changes in the past.

2. Improving access to comprehensive services

Another widely shared goal is to improve families' legal (as compared with physical) access to the full range of appropriate services they need. The current categorical system is rigid and exclusionary, providing a narrowly defined service or services for a specific population. Service integration strategies are designed to assure greater flexibility through modifying the various legislative and regulatory program requirements governing the types of services eligible families can receive. Specific tools and strategies used to obtain this increased flexibility are seeking waivers from federal or state regulations, or decategorizing several programs which target the same population which permits pooling of funds, loosening eligibility criteria, etc.

Although it is pointed out that such strategies can open the door to increased costs through expanding the range of services covered, recent service integration initiatives have aimed at budget neutrality, capping the total expenditures but providing the flexibility to spend them on preventive, home- and community-based services which are generally less costly and thus make the dollar go further. For example, the Medicaid waivers for home- and community-based care have to be budget neutral---the cost of the home-based services must not exceed the cost of institutional care. And some of the state initiatives under the CASSP program have also aimed at budget neutrality.

3. Improving service quality and effectiveness

The third major goal to improve quality and effectiveness of services is primarily through strategies implemented at the local service delivery level. Community-based demonstration programs are what many people think of when hearing the term "integrated services." These programs usually provide a comprehensive array of services to meet the needs of child and family in a more holistic and coordinated way. There is a great variety of program designs employed in these integrated services models. Most often these models provide a range of services co-located in one, easily accessible location---often a school. However, in some models services can be spread between sites but are carefully linked through tight referral and follow up mechanisms. In all these programs the goal is to meet, in a coordinated fashion, the multiple needs of the child, youth, and (in some models) the family.

Implicit in such a model is a high degree of collaboration especially at the community level in both the planning and implementation. Many elements of the community, including potential consumers, are closely involved in the initial planning of the program and in ongoing advisory or governance roles. There is also a great deal of ongoing collaboration among the roster of specialized service providers themselves. A critical component of this model is generally a case manager. The case manager plays a key role in helping the family get access to, coordinate, and monitor the range of services they need. Additional tools include a single point of intake, case conferences, and home visits. Another important theme in many of these models is a philosophy

of family empowerment in which the parent or other family members are viewed as collaborative partners helping to set and implement the service goals with the service professional.

These service integration demonstrations generally draw heavily on state and federal categorical funds though often waivers are sought to provide the needed flexibility. But additional resources are usually needed including direct demonstration grants from the state and federal government and from private foundations and other private sources.

Another very important variation of community-based, services integration is the creation of comprehensive, family-centered systems of care. In fact, **systems development** is the preferred term to services integration by those who are working with children and families with special health care needs and seriously troubled children. For both these populations a complex array of specialized services which vary over time are needed. But it is neither feasible nor necessary to place them all together under one program. What is needed is careful, collaborative systems development at state, county, and neighborhood levels to assure that these services are available to these children and families when and where they need them.

These comprehensive, integrated, community-based programs or systems of care have been created without for the most part any major financing or organizational changes at state and federal levels. But for this reason their financing and administration is complex, time consuming; and very unstable. It is generally agreed that financing and other reforms at state and federal levels would greatly facilitate and stabilize these local initiatives.

Patching the present system together or moving towards the new services paradigm?

As we shall see in the next section, reforms and demonstrations such as these are being implemented, and more are being proposed, in all the major service sectors. The reforms recommended by members of the service integration movement differ a great deal in how far reaching and extensive they are. Some---the "skeptical realists"---propose quite limited reforms at state and federal policy levels. Their goal is simply to help the present system of categorical services work somewhat better and more efficiently.

But others---the "optimistic visionaries"---believe that it is essential to move beyond the piecemeal, patch-up approach and to proceed, brick by brick, to institutionalize what many of them call the **new services paradigm**---a vision of an integrated, comprehensive, community-based and family-centered services system. This does not, its proponents assert, require totally dismantling the categorical service system. It does mean having a clear vision of what service systems should look like at the service delivery level and then developing the horizontal and vertical systems needed to make this vision a reality.

The key elements of the new paradigm include:

---serving a broad generic population group rather than only providing care for specific diseases or conditions;

---making available a comprehensive, system of services that form a continuum of intensity and address the whole child or adult not just separate pieces of them;

---locating services in or near the home and community;

---coordinating services in such a manner as to reinforce and complement each other;

---making services family-centered, that is services that respect family strengths and diversity, build on families' resources, and provide services to the family as a unit;

---viewing family members as collaborative partners in the service delivery;

---involving families to represent the views of consumers in service and program planning, policy development, and implementation.

HISTORY OF SERVICES INTEGRATION

(Sources: Fishman & Dolson, 1990; Office of Inspector General, 1/91 a &b; Institute of Medicine, 1982; Services Integration Pilot Projects, 1989)

The present interest in reforming services through integration has a long history. For decades, social workers and other human service professionals have been aware of, and struggling with, the problems inherent in the fragmented system of categorical, public/private services. The settlement house movement at the turn of the century was designed specifically to bring together in an accessible, neighborhood location a wide range of services needed by the poor.

Indeed much of the new "technology" of services integration---case management, case conferences, and outreach via home visits---represents a rediscovery of, and giving new shape to, tools that were once part of the social worker's standard repertoire. (In recent decades most social workers had stopped doing home visits, but public health nurses continued the practice in many communities.)

In the sixties and seventies, however, the interest shifted to a higher governmental level. Human service administrators and policymakers at county, state, and federal levels began to take note of the inefficiencies, complexities, and other costs of the escalating number of specialized categorical services. In response, many of the programs of the War on Poverty in the sixties devoted substantial attention to delivering a coordinated array of services in low-income neighborhoods.

In the early seventies the services integration concept attracted the attention of the Secretary of DHEW, Elliott Richardson. He coined the term "hardening of the categories" and proceeded to launch an ambitious agenda to promote services integration including research and demonstration projects, technical assistance efforts, and internal departmental reforms. He proposed the Allied Services Act, which would have allowed HEW to make planning and implementation grants to state and local governments to waive certain federal requirements and transfer funds from one categorical program to another. This bill was also promoted by Caspar Weinberger, HEW Secretary under President Nixon, however, in spite of repeated attempts this legislation never gained congressional approval.

On June 1, 1971, in a memorandum titled "Services Integration-Next Steps," Secretary Richardson outlined his concept of services integration (SI).

> *"Services integration refers primarily to ways of organizing the delivery of services to people at the local level...Services integration is not a new program to be superimposed...rather it is a process aimed at developing an integrated framework...Its objectives must include such things as (a) the coordinated delivery of services for the greatest benefit to people; (b) a holistic approach to the individual and family unit; (c) the provision of a comprehensive range of services locally; (d) the rational allocation of resources at the local level so as to be responsive to local needs." Changes such as decategorization or consolidation of programs, elimination of*

duplication of competing agency efforts, decentralization of decisionmaking powers, and simplification of administration and grant procedures can all make a useful contribution..."

All over the country SI initiatives proceeded to develop and were nurtured by HEW at both the service delivery and county/state administrative level. However, when Joseph Califano became Secretary in 1977 the Department's services integration efforts were losing momentum and Califano devoted his energies to welfare reform and national health insurance. Initiatives continued, however, at state and local levels, energized in part by the enactment of block grants in 1975 and 1981 which gave the states greater flexibility in their use of funds. However, the budget cuts of the eighties curtailed some of these reform efforts.

In the mid-eighties attention to services reform once again resurfaced at the national level and people seemed quite surprised to find out how many collaborative and cross-system initiatives were underway in communities and states across the nation.

Two recent reports from the DHHS Office of the Inspector General review the extensive body of literature from this earlier period and describe and analyze several waves of demonstration projects funded largely by the federal government. These waves were:

---**Services Integration Targets of Opportunity Research Projects (SITO).** Beginning in 1974, 35 demonstration projects and 10 technical studies were funded, most of them for three years, many by the Social and Rehabilitative Services agency in HEW. These projects were comprehensive service delivery efforts carried out by State or local governments or private sector organizations and intended to provide information that would help entities replicate these initiatives.

---**The Partnership Grants Program** was launched in FY 1974 to help state and local general purpose governments to improve their capacity to plan and manage integrated human services. About 79 projects were funded over the next three years.

---**Comprehensive Human Services Planning and Delivery System Projects (CHSPDS).** Five three-year grants were awarded in the late seventies to focus more specifically on planning and management issues. Their major thrust was intended to test the implementation of ten management elements such as a taxonomy of services and problems, cost accounting and case management systems. Regrettably these projects had major cutbacks in funding in their last year which hurt their evaluations. No cross-project evaluation was conducted.

---**Services Integration Pilot Projects (SIPP).** In the Deficit Reduction Act of 1984, Congress authorized federal funding for SI pilot projects designed to help individuals and families achieve or maintain self-sufficiency. Grants were awarded to five states---Arizona, Maine, Oklahoma, South Carolina, and Florida. Each was responsible for addressing nine service integration mechanisms to be used in common including: comprehensive family profiles, unified budget and accounting systems, co-location of services, uniform application and eligibility procedures, and standardized procedures for purchase of services. Although a report summarizes the lessons learned by program managers and personnel at each site (SIPP, 1989), a planned cross-site evaluation was never completed because of problems experienced by the contractor.

HHS/ACF awarded a task order contract entitled, "Evaluation of the HHS SIPP" on September 24, 1991. The contract calls for the contractor to conduct a brief case study of each of the five projects; to determine what overall cross project conclusions might reasonably be drawn about the effectiveness and efficiency of the SIPP effort; and develop a users guide to exemplary

practices in services integration on the basis of the SIPP experience for use by state or local governments.

Additional Department supported activities that complemented and nourished these SI demonstrations included the establishment of Project SHARE, in 1974-75, which was a national clearinghouse to help improve the management of human services. In its early years SHARE concentrated on assembling and disseminating the accumulating body of literature on SI. Around 1979-80 the Office of Human Development Services funded a National Network for Coordinating Human Services, which sought to develop and maintain linkages between individuals and organizations interested in "coordinating services that cross categorical boundaries, governmental jurisdictions, and public and private services." In the early eighties the network funded two national conferences.

All these SI initiatives were concentrated in the broad area of social services. However, there were parallel developments occurring to improve the delivery of primary health care which were summarized in a report of a study on health services integration conducted by a committee of the Institute of Medicine in 1982. The committee investigated on site six exemplary projects and reviewed reports of many others. Using federal grants of various kinds---such as improved pregnancy outcome funds and children and youth health services grants---leaders in the health care community had creatively pulled together a wide range of services using a number of SI models and tools. Sites for these programs were varied but several were neighborhood health centers.

Both the OIG and IOM reports synthesize the many lessons learned in these demonstrations about key components of successful SI, barriers they encountered, and strategies to overcome them. In some respects these projects disappointed what were undoubtedly unrealistically high expectations. Although the projects had positive short-term success, in the longer run they exerted little impact on the broader institutional service structures. Yet, in general, those in the field seemed to feel very positive about the results, believing that many clients received more and better services. However formal, quantitatively oriented evaluations were few and when they existed, did not relate their efforts to client outcomes, were not experimental in design, and only a few were able to document some cost savings.

Currently the main value of these experiences in the seventies and eighties is to alert this new generation of services reform to the many complexities and barriers to implementing SI and to the importance of sustained funding, strong leadership, and the need to pay attention to nurturing the personal relationships that prove essential to successful implementation of such collaborative ventures.

New elements in services integration

The intense current interest in service integration and coordination builds on many of the same roots and concerns but has at least five distinctive new features. First, is its much greater breadth and depth. As noted in later sections of the report, the interest and activity is occurring in every human service sector. Most striking, for the first time education is interested and taking an active role. Second, the reforms are being initiated simultaneously from top down and from bottom up. Third, the rapidly evolving new computer technology makes possible tools like computerized, one stop applications and eligibility determinations that were not previously available. Fourth, it is occurring in a time of serious fiscal stringency at federal and state levels. Thus the emphasis on SI as a possible route to reducing costs is even more intense. Lastly, the current reform movement is more clearly focused than earlier SI efforts on the importance of viewing the family as the unit of service and is evolving new technologies and approaches for implementing family-centered services.

PROGRAM SCOPE OF CURRENT INITIATIVES

Every major program sector involved in providing services to children and families has shown a good deal of recent interest in service coordination, collaboration, and integration. At all three levels of government there have been new initiatives and demonstrations, some within the broad program area (e.g. health care) and others across sectors. These trends are summarized below by program sector (health, education, child care) or program population (low-income, disadvantaged, and seriously troubled children). In each brief description we focus primarily on trends at the national and federal level but provide a few illustrations of developments at state and local levels. (These will be examined in more detail in future reports.)

One of the interesting results of providing such a broad overview is to note that similar financing, administrative and case level strategies and tools are used in the different sectors even though they have developed quite independently of one another. This means that service integration projects at a local level often look very similar in design even when they emanate from different sectors and serve a somewhat different population group.

Employment, Training and Public Assistance Programs

(Sources: Corbett, 1991; Harris, 1991; Jennings, 1991; Jennings and Zank, eds., 1992; King, 1991; Levitan et al., 1989; Zank, 1991)

About 75 federal programs provide assistance to poor families in the form of cash payments and assistance in paying for food, housing, energy, medical care, education, jobs, and training. These programs are scattered across six federal departments. At least 11 congressional committees and numerous subcommittees exercise primary authorization, appropriations, and oversight over these programs.

These programs target the same general poverty population and share broad objectives---to help poor individuals and families with their basic daily living needs and to help them take steps to become more economically self-sufficient. Since each program has its own legislative base and is administered by separate bureaucracies this leads inevitably to much program fragmentation and conflicting rules and regulations.

There are two main categories of problems:

---**Definitions and rules conflicts**. Among the programs there are different legislative requirements and regulations governing who is considered eligible for the assistance, how income and assets are defined and documented, and how family and household units are defined. The programs use different performance standards, have different data requirements and reporting timetables. Since many of the poor participate in, or seek to participate in several of these programs, these differences can serve as significant program barriers for the clients themselves. (Many federal entitlement programs are substantially under-enrolled.)

---**Bureaucratic fragmentation**. Responsibility for planning, implementation, and monitoring of these related programs is scattered widely in different agencies and departments across the federal government. This results in much duplication, waste, and many other management problems and inefficiencies and leads to confusion, serious inconvenience, and ineffective service for program clients. This fragmentation is mirrored at state and local levels.

Not surprisingly there have been many studies and much discussion and debate about how to improve the coordination and integration of public assistance programs. At state and local levels

there have been several initiatives and demonstrations, sometimes funded in part by private foundations, to coordinate and integrate welfare, education, and training programs particularly for high-risk populations. These include, for example, the Manpower Demonstration Research Corporation's demonstration programs for teenage parents, and the Rockefeller Foundation's funded program for minority single-parent families. Among the strategies used are interagency task forces or coordinating councils, interagency agreements and joint funding, and tools such as co-location, integrated case management, and computerized case tracking and providing support services such as child care.

One highly family-centered demonstration which has received a great deal of attention is the Lafayette Court Family Development Center situated in a Baltimore housing project. This center provides an extremely comprehensive set of services on site for parents and their children, including adult education, developmental child care, health services, programs for teenagers, and recreation programs for the whole family. It also serves as the point of intake for all activities funded by the JTPA and JOBS system. The Baltimore's JTPA agency is the lead agency in coordination with many other departments which provide joint funding for the center.

At the national level, several initiatives have examined changes that could be made in federal legislation and regulation to simplify, streamline, and coordinate these programs. Recommendations were made, but little has happened. For example, the Carter Administration established an interagency study of eligibility simplification in the seven major federal assistance programs. The detailed report was published in October 1980. Its numerous recommendations were ignored.

In the late eighties the Select Committee on Hunger had a series of hearings on welfare simplification and the General Accounting Office published a series of reports on the subject. All concluded that changes were needed. The Family Support Act of 1988 required the welfare, education, and JTPA agencies to coordinate with each other but no incentives were provided for them to do so. Moreover, many believe that setting up a new employment and training program---the JOBS program---administered by DHHS instead of the Department of Labor, has only added to the fragmentation of expertise and effort.

Most recently, the Food Stamp Reauthorization Act of 1990 included a provision for a Welfare Simplification and Coordination Advisory Committee which was asked to make recommendations for common or simplified programs and policies within the AFDC and Food Stamps statutes. Although due to report in July 1993, as of September 1991 the members of the committee had not been appointed and the work had not begun.

National Commission for Employment Policy (NCEP). Spurred by the finding that Hispanics were not entering JTPA-sponsored training and employment programs, in part due to their desire not to apply for food stamps, in 1990 the NCEP launched a major inquiry on Improving Coordination in Government-Sponsored Public Assistance Programs (see p 32). At hearings and conferences across the country, state and local level officials reported that considerable progress has been made in many localities in co-locating services, joint application forms, and so forth. However, making further improvements was a difficult task without changes being made at the federal level.

The NCEP final recommendations, were issued in early October 1991 in the form of letters to the President and the Congressional leadership. Theses recommendations address the range of actions needed at the federal level to support, encourage, and facilitate federal, state, and local level coordination of public assistance programs. These recommendations address needed presidential leadership, strengthening the White House Economic Empowerment Board, administrative

reorganization, a new congressional joint committee on public assistance, and several legislative remedies.

Seriously Troubled Children and Families' Services

(Sources: Knitzer, et al. 1978; Knitzer, 1989; Ooms, 6/90; Ooms & Beck, 1990; Robison, 1990; Soler & Shauffer, 1990)

Troubled children and youth are served by four systems---child welfare, child mental health, juvenile justice, and youth services (e.g. runaway youth programs). The past few years has seen a growing interest in creating cross-system collaborative initiatives and creating more flexible financing. This new interest is fueled, in part, by a desire to keep these children out of expensive institutional care which is often believed to be unnecessary. The majority of funds in all four systems is spent on placing children in out-of-home care. Funding of preventive and community-based services is severely limited or non-existent.

Since the late seventies the case for improving the coordination and integration of services for troubled children has been strongly argued by advocates and child welfare and mental health professionals. Several reports noted that children in these systems had similar problems and came from similar backgrounds. They noted the arbitrariness of the diagnostic labels placed on a child which would determine which system would provide him or her with services and the type of service. The children would often be bounced around from system to system depending on the particular incident or type of behavior that attracted attention.

These points can best be illustrated with a case example: a troubled 14 year old girl, Jane X, began her career in the Youth Services system when she ran away from home and stayed for a while in a runaway youth shelter. The staff then noted her dependence on drugs and sent her to a drug rehabilitation residential program. After her parents' insurance ran out she was transferred to a public psychiatric inpatient ward for adolescents and when she finally returned home she was picked up for shop lifting and put on probation. The probation officer learned that her step father had been sexually abusing her, filed a child abuse report and the girl ended up placed in a foster home. Throughout this story Jane, as well as her family, needed, but did not receive, skilled mental health counseling. She also needed, but did not get, remedial education services and gynecological care. The next year she got pregnant.

In the early eighties both the child welfare and mental health systems were confronted by escalating rates of out-of-home care: foster care rolls were rising, in some states many seriously emotionally and mentally disabled children were being placed in institutions out of state, and there was a sharp rise in psychiatric inpatient hospitalizations for teens. Both systems began to realize they shared the overarching goal of providing services to keep troubled children living in their homes and communities and this has formed the basis for a new collaboration between systems.

Child and Adolescent Service System Program (CASSP)

Leadership in both systems began to articulate new models of community-based, service delivery that would redirect resources from out-of-home care. A tiny federal program, the Child and Adolescent Service System Program (CASSP), instituted in 1984 has developed and promoted a model for comprehensive, community-based systems of services for seriously troubled children. This model lays out the continuum of services needed in a community and a series of principles to guide the way these services should be delivered. One key principle of the CASSP model is to develop strong linkages between all the various systems serving children throughout the planning,

developing, and implementation of services. Another key principle is that families should be full participants in all aspects of planning and delivery of services.

These CASSP funds granted to states have served as catalysts for many new initiatives at state and local levels to form cross agency collaborations which undertake joint planning, joint funding, cross-system training, central intake, multi-team assessments, and case management involved in implementing the CASSP model.

Family Preservation Services

A parallel and complementary innovation in service delivery---family preservation---originated in the child welfare system but is now being used within and across all systems for troubled youth. Child welfare, mental health, and juvenile justice funds are all being used to support family preservation programs in about two dozen states. Private foundations---notably the Edna McConnell Clark Foundation and the Annie E. Casey Foundation---have played a pivotal role in funding these reforms.

Family preservation is both a philosophy and approach to working with families whose children are at imminent risk of being placed outside the home. There are several different models of family preservation---the best known and most widely replicated being Homebuilders---but they have many features in common and all challenge traditional modes of categorical service delivery. Family preservation provides highly intensive, short-term counseling, therapy, and parent education services to families in their home setting, and mobilizes whatever practical resources are needed to help the family function better. Unlike traditional services, no diagnostic label is required to access family preservation services. Also there are no restrictions on the type of service that can be provided, it is left up to the caseworker's judgement to determine what services are needed and appropriate. Several states are moving towards statewide replication of family preservation programs and to do so often requires system-wide reform.

Flexible funding is a key to these reforms. States, which to date provide the bulk of the financing, have shown great creativity in finding sources of funding through state general revenues, granting waivers to communities to pool funding, and some decategorization of state programs. A few have found ways to tap Medicaid funds (the rehabilitation services options) and some federal child welfare dollars (Title IV-E). One reason these reforms have attracted such strong state legislative support is the promise of reducing costs. However, while there is some evidence that these reforms may reduce overall costs, reform proponents currently stress that the principal objective should be to maintain budget neutrality while achieving better outcomes for children and their families.

There is general agreement that categorical barriers at both federal and state levels remain a serious impediment to the children's services reform movement. The proposed reforms focus on providing more flexibility in how the federal funds can be spent and to a lesser extent on who may receive funded services. Legislative proposals for decategorization of the major child welfare programs on a demonstration basis were introduced into the U.S. Congress in 1991 (see p. 27).

Another state and local response to the fragmentation of children's services has been to reorganize governmental administrative structures and create new coordinating bodies. At local and state levels various kinds of interagency coordinating councils and committees have been set up, some legislatively, to facilitate and nurture collaborative planning and implementation. In the past two decades many states have moved to consolidate the administration of children's services quite substantially. However, a recent survey revealed that while the new structures bring some benefits they can also create new problems (for details see Robison, 1990).

Education
(Sources: Lara & Hoffman, 1990; Levy & Copple, 1989; Melaville & Blank, 1991)

The interest in collaboration and service integration strategies in the education sector has emerged haltingly in the past few years. Apart from a few isolated models---such as Dr. James Comer's Baldwin-King demonstration school in New Haven---and the local initiatives of mental health or social service agencies in certain communities to provide consultation and outreach services in schools, educators had for the most part eschewed working with the other human service agencies. At best, minimal levels of coordination of referrals occurred. Schools had attempted to take care of the non-educational needs of their students themselves with totally inadequate resources, or would export these needy students by referral to agencies in the community for services.

Collaborations. Two major forces have contributed to education's new interest in collaboration. First, the Family Support Act of 1988 mandated that appropriate educational services be made available to all participants in the new JOBS program, and required they be provided to teen parents under age 20 who had not completed high school or its equivalent. These provisions, especially those for teenage parents require a high degree of collaboration between schools and welfare agencies---two systems with radically different organizational structures.

The second trend impelling schools into collaborative activities was their awareness that they were failing to educate large numbers of disadvantaged kids, and that this was in large part because so many emotional, social, and environmental factors were interfering with these students' ability to learn. Educators began to see the value in developing collaborative programs with other agencies that would serve these youngsters in a more holistic and coordinated way. Within the last few years numerous schools and school districts have joined forces with other agencies and community leaders to plan and operate collaborative projects aimed at, for example, school-drop out prevention. Increasingly schools are involved in more broadly focused services providing a range of comprehensive health and social services to high school students, generally on school grounds. A dozen or so states are already investing substantial resources into such centers. These joint initiatives are being monitored and encouraged by the Joining Forces project (a collaboration of the Council of Chief State School Officers and the American Public Welfare Association), the Institute for Educational Leadership, the National Association of State Boards of Education, and the Center for Population Options, Resource Center for School Based Clinics.

Decategorization. The federal education dollar is much less important a funding source for education than state and local funding, thus, until recently there has been very little discussion about the need to decategorize education programs. However three major federal education programs focusing on disadvantaged, at risk, children provide numerous examples of the difficulties caused by separate categorical funding streams (see Highlights pp. iv-vi). Several organizations including the National Governors' Association, the Council of Chief State School Officers, as well as the U.S. Department of Education are launching a study to examine the legislative and regulatory barriers at federal and state levels towards achieving the goals of compensatory education programs (Chapter 1), special education, and bi-lingual education with the goal of making recommendations about possible decategorization

Many schools are now providing a whole range of preventive education programs ranging from alcohol and substance abuse prevention, smoking, pregnancy, AIDS prevention, and suicide prevention. These programs in general receive categorical federal funding and are operated independently from one another although they are largely targeted on teens "at risk." These prevention programs would seem to be a logical candidate for decategorization.

Child Care and Early Childhood Programs

(Sources: Goodman & Brady, 1988; Ooms & Herendeen, 1989; Ooms & Golonka, 1990; Robins, 1988)

When a broad definition of child care is used (including tax assistance and all types of non-parental care), the federal government currently provides child care assistance to families through at least 24 separately funded programs, many of which are targeted to low-income families. These programs are administered by several federal departments and agencies and there is no central coordinating office at the federal level. In addition, many states and localities provide additional funding for various kinds of child care assistance, including a considerable investment in preschool education. At the local level nearly a dozen local departments or agencies of county government have some involvement in providing child care services in addition to dozens of private organizations and agencies (both for-profit and non-profit).

At the local service delivery level child care programs often draw upon multiple sources of funding. Since many of the programs have different eligibility and other program requirements, considerable confusion results. One effect is that as their income changes, in order to maximize their subsidy, poor parents may have an incentive to move their child from program to program.

Different types of child care are regulated differently by the state, and are treated differently by zoning authorities. Some kinds of child care subsidy can only be spent on regulated care yet child care assistance through the tax code is not regulated---i.e. parents can choose to employ anybody no matter what their qualifications as their child care provider.

A particular problem arises when trying to integrate Head Start programs, or preschool education programs with each other or with other types of care in order to obtain full-day care for employed parents (Head Start and preschool are typically half-day programs). For example, Head Start programs have particular curriculum and parent involvement requirements which other programs do not. Head Start programs are often competitive (for children and staff) with preschool education programs which have higher staff/child ratios and pay their teachers much higher salaries.

States and communities have responded to this confusing patchwork of child care programs primarily through setting up child care information and referral services. These services play a very useful role in helping parents find appropriate care and assisting public agencies in the implementation of child care programs such as the JOBS assisted child care.

Some counties have set up a comprehensive child care agency to coordinate the numerous child care programs. For example, the Office for Children in Fairfax County, Virginia has been able, with the assistance of state waivers, to meld all the funding streams together and establish one fee schedule policy across all publicly funded programs.

The federal government has done little to promote coordination of child care or to provide technical assistance to state or localities in how to commingle funds. In the early seventies, the Office of Child Development funded an extensive national network of Comprehensive, Coordinated Child Care programs designed to promote coordination. But their effectiveness was very limited, largely due to a shortage of funding.

Comprehensive, Family-Centered Models

The federal government, however, has made a major contribution to the development of innovative models of preschool and comprehensive and integrated services for families. The best known is

the **Head Start** program which is a 25 year old federal program of direct grants to community level entities.

All Head Start grantees are required to offer comprehensive health, education, and social services to the enrolled children either on site or by referral. Parent involvement was required, and program social workers were available to meet with parents to help them get services to meet some of their own needs.

In addition, in 1987, a new grants program under the Head Start umbrella was established, the **Comprehensive Child Development Programs** which provide an even more intensive, family centered model of integrated services. An explicit goal of these programs is to prevent welfare dependency and promote self-sufficiency. A wide range of core services are to be provided for the child, and parents must be provided with parent education, job and vocational education, counseling, and placement upon request. Case managers must work with families to prepare Family Needs Assessments and Family Service Plans, and must conduct weekly home visits. The 24 funded programs have built an elaborate set of collaborative relationships with other community service agencies in order to form an integrated service system for the programs' families. (Abt Associates is conducting the impact evaluation, CSR, Inc. is conducting the process and feasibility evaluation.)

Health Services for Children and Families
(Sources: AMCHP, 3/89; Bane & Lusi, 1991; Gittler, 1991; Ooms, 3/90 & 10/91; National Commission to Prevent Infant Mortality, 4/91)

Although most of the public debate on health care focuses on controlling health care costs and finding ways to provide coverage for the uninsured, there is increasing interest in the health care field in improving the effectiveness of current service delivery systems for children and families. Coordination and integration are emerging as major themes to strengthen the effectiveness of the multiple health services needed by three population groups: low-income pregnant women and mothers, infants and children; and adolescents "at risk" and children with special health care needs.

In recent OBRA legislation eligibility for Medicaid (Title XIX) was expanded to assure that all pregnant women and children under age six in families with incomes below 133% of the federal poverty line can receive coverage. Also a wider range of home- and community-based services---including case management, care coordination, and home visiting---are now reimbursable services. In addition, the EPSDT/Medicaid program has been expanded to cover the treatment of any conditions that are diagnosed in the screening examinations.

Title V, the next major federal source of primary maternal and child health care (MCH) and care for children with special health care needs (CSHCN) is already a block grant and thus states have considerable flexibility in how they spend their funds, although certain percentages of the funds are earmarked for certain population groups. But the 1989 OBRA legislation introduced new language in the purposes section of Title V that specifically promotes "family-centered, community-based, coordinated care" and adds a set-aside for new demonstrations which include home visiting programs and systems to integrate service delivery.

The Medicaid and Title V programs are administered by different divisions of DHHS and by different agencies in the large majority of states. The Title V block grant requires coordination of these two programs and nearly all states have developed formal interagency agreements between them. In addition, 45 states recently reported that their Medicaid program had adopted MCH/CSHCN program standards in at least one area (AMCHP, 3/89).

Low-income pregnant women, mothers, infants, and young children

Joint application forms. An important requirement in the OBRA '89 legislation was that the DHHS Secretary was required to develop (in consultation with the Secretary of Agriculture) a model application form which would enable pregnant women or mothers with children under age six to apply jointly for assistance from several related programs including Title V, Medicaid, WIC, Head Start, Homeless, and Community and Migrant Health Center programs.

In preparation for this task the Association for Maternal and Child Health Programs was asked to survey the states about model joint application forms that were already being used or were being developed (22 states in total). The states reported that they encountered numerous barriers in regulations, rules, definitions, and eligibility requirements among the various federal programs---such as different definitions of household composition and assistance units, income, type of documentation, etc. (State-level barriers were also cited.) While states had found ways to overcome some of these federal barriers, they believed that others needed to be changed at the federal level (see AMCHP, 11/91).

The National Commission on Infant Mortality has actively promoted several new approaches to improve coordination, streamline service delivery, and improve physical access and effective services for low-income mothers and children. This would include joint application forms, expediting eligibility, computerized application systems, and aggressive outreach efforts including home visiting and "one-stop shopping," i.e. co-locating related services. Recently, the Infant Mortality Commission has joined forces with the Institute for Educational Leadership to form a new health/education consortium (see p. 31).

A new Administration initiative, **Healthy Start,** incorporates many of these concepts. This program taps some existing money and adds some additional funding to provide grants to ten cities with high infant mortality rates. These model programs will deliver a range of comprehensive services including outreach and substance abuse treatment services to pregnant women, mothers, and babies at risk. The specific goal of these grants is to reduce the infant mortality rates by 50% within five years.

Adolescents at risk

Among the earliest models of comprehensive integrated services were community-based, comprehensive, on-site, health related services for street youth set up in the sixties---among the best known was the Door in New York. Following these were comprehensive health, education, and social services provided to pregnant teenagers and teen parents which began to be established in many communities in the late seventies. Many of these received demonstration grant funding from the federal Adolescent Family Life Office. These programs provided some services on site and some by referral. Nevertheless, this comprehensive approach to adolescents formed the exception.

As a recent OTA report pointed out, most health and related services to adolescents at risk suffer from all the problems of fragmentation that have been discussed in this report, in addition to some that are specific to adolescence. Several major reports on adolescent health conclude that the medical and other service systems fall far short of meeting teenagers' health related needs. There is now much greater awareness of the interrelated needs of adolescents, and the interrelatedness of adolescent health damaging behaviors. There is a great deal of interest in models of school-based, multi-service centers for youth and by one estimate nearly 300 such centers already exist. At least eight states are now making a substantial direct investment in these types of programs. These services require a tremendous degree of cross-system and within-system collaboration and

coordination. And as communities search to stabilize their funding, they will undoubtedly be pressuring for greater flexibility or even decategorization of current sources of funding. (For more detail see background briefing report on this subject by Ooms and Owen, 1990.)

Children with special health care needs

During the seventies advocates brought to public attention the needs of handicapped children for a wide range of health, education, and social services. In 1982, Surgeon General C. Everett Koop launched a series of national and regional workshops on children with special health care needs. The report emerging from these workshops argued strongly for the need to develop comprehensive, coordinated, community-based and family-centered systems of care for these children and their families. In 1986, the passage of the Education for Handicapped Amendments, P.L. 99-457, Part H, enshrined these principles into federal law in the Handicapped Infants and Toddlers program. This program provides discretionary funds to states "to develop and implement statewide, comprehensive, coordinated, multi-disciplinary, interagency programs of early intervention services for handicapped infants, toddlers, and their families." In general, these Part H funds were to be used as "glue" money, spent primarily on activities related to planning, cooperation, and coordination, and needed to implement the goals of the legislation. States were given five years to phase in their implementation of the program.

This Part H program incorporates several additional components of services integration and especially has a strong emphasis on coordination and collaboration at all levels of government. The U.S. Department of Education is the lead agency but eighteen separate programs, based in seven separate agencies within DHHS, also fund some services to this population. Another seven programs provide training, research, technical assistance, and model demonstrations development, all of which are designed to improve the quality of services for special needs infants and toddlers. A Federal Interagency Coordinating Council was set up to improve collaboration between all these units at the federal level.

The law, P.L. 99-457, requires states to establish Interagency Coordination Councils, again with one agency taking the lead to assure that the required collaboration occurs between the numerous offices and bureaus that deliver services to this population at the state level. Communities are given a great deal of flexibility but the law requires states to assure that within five years all infants and toddlers with developmental delays and diagnosed conditions and, at state option, children "at risk" of these receive a comprehensive, multi-disciplinary assessment of the needs of the child and a determination of the families' strengths and needs so as to develop an Individualized Family Services Plan for each child and family. This plan must include case management services. The law requires that parent representatives be included in policy planning and development.

In 1989, amendments were enacted to the Title V MCH services block grant to redefine the mission of the State Programs for Children with Special Health Care Needs by mandating that they assume a leadership role in developing community-based systems of care. In order to provide help to the states in implementation of the law the Federal MCH Bureau, CSHCN Division formed a Work Group on Systems Development which is planning a technical assistance effort to states (see Gittler, 1991).

WHAT IS THE FEDERAL ROLE IN SERVICE INTEGRATION?

(Source: Bane and Lusi, 1991; Gimpel, 1991; Jennings & Zank, eds., 1992; King, 1991; Morrill & Gerry, 1990; National Governors' Association, 1991)

In this section we review a variety of ways in which people have suggested that the federal government could initiate, promote, or support services integration at state and federal levels. Some would require much more radical reform---and hence be expected to encounter much more serious resistance---than others. Some suggested integrated services reform strategies would require legislation, some, modifications of regulations and others would simply require administrative decisions. Many of these strategies could also be adopted by state governments.

After surveying the range of strategies available to the federal government with respect to coordination of public assistance programs, one analyst recently wrote,

> *"...the key federal actors may be unwilling to get their own house in order. However, the least they can do is to provide a modicum of assistance to those who are suffering daily from their messiness. On the cheap side, they could support existing state and local efforts to provide one-stop shopping and to design and operate seamless services; or, they could develop and disseminate multi-program eligibility software via a national TAT project. On the more costly side, Congress, the White House and the key federal agencies could commit their energies and resources to housecleaning on a grand scale, designing a more rational, cohesive system of programs for the disadvantaged (King, 1991)."*

(i) Leadership

There are many obstacles to changing long established systems and patterns of service delivery. When efforts have been successful in the past leadership from the top has been perhaps the most critical ingredient. Thus, at the federal level the strong support and encouragement of the White House and key Congressional leaders will be essential. The National Commission for Employment Policy's first recommendation to the President addresses the need for his leadership, "the most powerful remedy you possess is the prestige, visibility and strong leadership that you could provide to support initiatives that would enhance program coordination." The Commission also recommends that the President launch a public information campaign by "vigorously advocating (creative) approaches among the public, social service professionals and political leaders." Thus far the interest of the White House in this issue has been expressed by their support of the AEI/White House project on Integrated Services for Children and Families. Many believe that leadership is equally necessary among the members of Congress.

At the Department level leadership is also critical. DHHS Secretary Sullivan early in his administration established seven overarching goals for the department and nine program directions, of which three addressed improving and integrating services for low-income children and families as follows.

> *Program direction #5. Improve access of youth living in low-income families to needed support services, including employment training, other transition to work services, and adolescent pregnancy-related services.*
>
> *#6. Improve the integration, coordination, and continuity of the various HHS funded services potentially available to families currently living in poverty.*

#8. Improve access of young children and their families living in poverty to a wide array of developmental, support services and income assistance, including nutrition, foster care, health, mental health, social, and child protective services.

The consolidation of the Family Support Administration with the Office of Human Development Services into the new Administration on Children and Families and several current initiatives in the Office of the Assistant Secretary for Planning and Evaluation reflect the Secretary's interest in this issue.

(ii) Increased program flexibility

The federal government can provide increased flexibility, within current legislative boundaries, in the entitlement and other categorical programs through modifying regulations and facilitating waivers to those who requested them. In health care, the Medicaid Home and Community waivers have been a very important source of assistance. In response to complaints that the waiver process, even when legislatively encouraged, was very cumbersome and time consuming, the Reagan administration in 1987 established the Low Income Opportunity Board (LIOB) in the White House. Its major function was to facilitate the waiver process. It acted, in effect, as a one-stop intake process for several waiver requests from a state which would be submitted as a single package. The LIOB would then assist the states to obtain these waivers from the federal agencies. Thirteen state projects were authorized through LIOB as of mid-1990 including the Wisconsin Learnfare and the New Jersey plan to permit AFDC recipients to become family day care providers.

In 1990 the LIOB was replaced by the Economic Empowerment Task Force which was supposed to continue its work and launch some new initiatives. The National Commission for Employment Policy also recommended that the President expand the authority and mission of the Task Force in a variety of ways.

(iii) Program decategorization

Decategorization of federal programs is an integration strategy that seems very radical although its twin, block granting, is very familiar. The Reagan Administration folded a large number of federal programs into block grants and came under serious criticism for doing so by the advocates because these changes were accompanied for the most part by cutting funding. In general, state and local governments like block grants for the increased flexibility they give the states. However, Congress has recently amended several pieces of block grant legislation to regain some greater measure of control in order to assure themselves that states would focus on certain populations in need through "earmarks" or "set-asides" of certain percentages of funds for specific purposes, e.g. for substance abusing mothers in the ADAMHA block grant. Now that once again the advocates are seeing the advantages of greater flexibility, it remains to be seen what strictures, if any, they would wish to place on such decategorization or block granting initiatives to make them more acceptable, such as protecting the level of funding and requiring reporting of how the monies was spent.

Decategorization would seem to be most appropriate for groups of programs that provide a complex array of services to a generic population group, e.g. child care or seriously troubled children, or prevention programs for teens "at risk." They would seem to be least appropriate for programs which simply provide income or in-kind transfers---e.g. Medicaid, SSI, Food Stamps, etc.---to a specific target population group. For these programs either simplification or greater flexibility appears the most appropriate reform strategy.

In April, the National Governors' Association responded to President Bush's block grant proposal in his FY '92 budget with their own counter proposal. The Governors recommended that 47 categorical grants, 3 direct loan programs, and 3 guaranteed loan programs be combined into a block grant with eight functional components totaling $15.2 billion. In addition, the Governors supported an optional pilot project in 5-10 states for the consolidated grant administration of AFDC, Food Stamps, and Medicaid (NGA, 4/91).

Several caveats were added to this proposal, notably, that funding should be guaranteed over five years at a level agreed to among the states, Congress, and Administration; in general, the block grant legislation should not include categorical eligibility requirements, earmarks, or other eligibility criteria, or authorize limited transfer of funds among or between the block grants. States should be allowed to waive any confidentiality requirements that stand in the place of integration. At about the same time, the National Conference of State Legislatures also worked on a block grant proposal which was quite similar to the NGA proposal. These proposals have gone to the White House but so far there has been no official reactions to them.

(iv) Government reorganization/consolidation

There are a few proposals around suggesting that certain programs with similar aims and target groups should be regrouped together under one administrative umbrella. The NCEP has recommended that three major employment and training programs be merged into one organization ---the USDA's Food Stamps Employment and Training program, Labor's JTPA program, and the HHS Job Opportunities and Basic Skills program (JOBS).

One recent rather dramatic move to consolidate programs in DHHS was the incorporation of most of the Office of Human Development Services into the Family Support Administration, to become the Administration on Children and Families. One of several arguments in favor of this reorganization is that it would bring several key child care programs together in one administrative office and these programs would also be more closely tied to the AFDC/JOBS program. As mentioned, administrative reorganization and consolidation have been tried a good deal at the state level---for example in the Community Human Services Departments in Wisconsin---but the benefits gained are not at all clear.

(v) Simplification and streamlining

As already noted, there have been, and continue to be, many studies and task forces examining how to reconcile and streamline the various eligibility criteria, definitions, and standards across programs targeting the same population. But to date there have been few changes made. This may reflect the difficulty of the task, but equally it may stem from nervousness about whether making the whole process of applying for assistance much easier and less forbidding will lead to much greater utilization and hence increased costs. One positive development, however, is the joint application for programs needed by pregnant women, mothers, and young children, required by the OBRA 1989 legislation. This task, administered by the Maternal and Child Health Bureau, is moving ahead and may be an exception to the general paralysis on this aspect of integration.

The NCEP has recommended that the Congress "enact legislative remedies to eliminate conflicting terms and definitions among public assistance programs" and that it "seek to unify (and thereby simplify) the poverty levels used in public assistance programs." A similar recommendation directed at the President by the National Commission on Children was to establish "uniform eligibility criteria across the major federal mean tested programs for low-income families with

children, including AFDC, Medicaid, WIC, and Food Stamps...and further recommends that states consolidate and streamline application procedures" (p. 326).

(vi) Creating structures to facilitate coordination

In almost every piece of recent legislation directed towards families there have been some requirements related to improving program coordination. Coordination has been described as "unnatural acts between non-consenting adults" and thus many believe that legislative mandates are insufficient by themselves unless they are followed up with economic or other incentives to coordinate.

The executive branch agencies do not have a strong record of coordinating its own activities or overseeing the coordination required in the field even when mandated to do so. For example, legislation that established the adolescent pregnancy and parenting grants program in 1978 gave the Secretary of DHHS a broad coordination mandate to "coordinate federal policies and programs providing services in relation to the prevention of adolescent sexual relations and initial and recurrent adolescent pregnancies and providing care services for pregnant adolescents...and required grantees to report on all policies that interfered with their mandate to provide coordinated, comprehensive services." The legislation also required the Secretary "to review all DHHS programs and policies to determine if they were consistent with the AFL program." No attempt has been made to follow up on any of these coordination requirements.

There are, however, an increasing number of interagency agreements between parts of the federal government which cover such things as joint request for proposals and joint funding of conferences. And the Department of Education held a conference in the summer of 1991 on the subject of coordination.

On the congressional side there has been a growing awareness of the need to promote coordination at state and local levels. For example, the JTPA program has an 8% set aside for coordination activities. The Food Stamp/AFDC program has state Coordinating Advisory Councils. In 1988 the ADAMHA Block Grant included a provision that alcohol and drug abuse programs will be coordinated with youth suicide prevention programs. The P.L. 99-457, Part H program requires Inter-agency Coordinating Councils at the state and federal level. However, there has been no comprehensive study about how effectively these structures are working.

Members of Congress have not yet seriously begun to tackle the issue of confronting the fragmentation of their own institution. The examples of failure to do so are legion. Typically, new legislation is enacted or amended with no reference at all to how these changes will affect closely related programs. For example, the 1986 P.L. 99-457 legislation for children with special health care needs made no reference at all to how it would relate to the Maternal and Child Health block grant program which is the major source of state funding for services for these children.

Congressional Reform

Several proposals are beginning to surface to nudge the Congress into putting its own shop in order. The National Commission on Children, recommended the "creation of a joint congressional committee on children and families to promote greater coordination and collaboration across the authorizing and appropriation committees with jurisdiction over the relevant programs."

The NCEP has made two quite far reaching recommendations about how the Congress should reform itself. First it recommends that the responsibility for legislation and oversight over all

public assistance programs should be delegated to a single committee. Failing this rather ambitious proposal they suggest a less radical plan, namely the establishment of a Joint Committee on Public Assistance that would conduct oversight hearings, etc. but not have any authorizing responsibilities.

A congressional analyst made a third suggestion, namely that intra-chamber conference committees be appointed to work out differences in statutory design between related programs emanating from different committees. These conference committees would meet after a bill had been passed out of committee and prior to floor consideration (Gimpel, 1991).

(vii) Investment in Technology

Computerized technology now makes possible many service delivery tools that previously had to be laboriously accomplished by hand---such as joint applications and case tracking. Several people have suggested that the federal government can play a unique role in developing the expert systems software for the categorical programs and marketing its availability among its own programs and providing technical assistance for its use. Indeed, the Administration for Children and Families is conducting activities to explore the use of computerized applications procedures. Some believe that computerizing eligibility applications makes it less urgent to create consistent terms and definitions which may in any case never be attainable for political reasons.

(viii) Encourage state and local experimentation

The federal government has traditionally played a strong role in funding small scale innovative demonstration programs and sometimes statewide demonstrations as a way of encouraging state and local experimentation. DHHS funded several services integration projects in the seventies, and more recently model programs such as the Comprehensive Child Development programs. The National Commission on Children's recommendations strongly reinforced this role for the federal government as have many others.

Most recently the Assistant Secretary for Planning and Evaluation has funded a National Resource Center for Integrated Services and several facilitator grants to both increase and centralize the evolving knowledge about integrated service models and provide technical assistance (see p. 34).

(ix) Other suggestions for congressional reform

The NCEP made several other interesting recommendations for congressional reforms including a requirement for an economic and fiscal impact analysis of proposed federal public assistance legislation that would include an analysis of impact on other assistance programs and the anticipated effect on clients.

In all the literature reviewed for this report no mention was made of the federal (or state) role in helping to train human service professionals to deliver integrated services. However, congressional analyst James Gimpel believes that one reason that federal legislation is so difficult to implement is that congressional staff lack experience and first hand contact with the details of program implementation. He contrasted the fact that staff on the defense committees are frequently treated, at Defense Department expense, to field trips to see the problems and achievements at first hand. Gimpel suggests that resources be made available to take congressional staff to social programs in the field (Gimpel, 1991).

ISSUES AND QUESTIONS FOR STUDY AND DEBATE

- **Costs.** Is services integration a strategy or group of strategies that is cost effective? There is very little hard evidence about how much additional resources are needed in order to make these various reforms effective nor about the extent to which the reforms reduce or increase budgets overall. It is not clear this is a question that will ever be able to be answered in a global sense since the problems of evaluation design loom large. (For example SI may involve additional costs in the short term for the sponsoring agency but save costs in the long run for society in services not needed in the future.) But it may be possible to document some effects on costs at the local demonstration level where some well-designed projects are beginning to get some cost benefit information.

- The many **barriers** to services integration must not be underestimated. They need to be studied to determine what ways, if any, there are to surmount or bypass them. These barriers include the following.

  ---Variability of state fiscal conditions can seriously hinder states' ability to initiate and sustain new program initiatives.

  ---The instability of political leadership, and their consequent short time horizons leads to insufficient time to create the necessary stable, sustained commitment and support for any integration initiative.

  ---The turf and ownership problem has three dimensions; political, professional, and bureaucratic. Policymakers are loath to give up any authority over separate, visible categorical programs with which they have become identified. Similarly, advocates are loath to lose the program identity for fear, with some reason, that political support and funding will be less forthcoming. Likewise, specialized programs or professionals are loath to give up their identity and fearful that if they are subsumed under some type of "generic" service the quality of services to families and children will suffer. Bureaucrats are reluctant to get involved in integration activities which require, as many do, they give up control over all or some of their funding.

  ---Services integration lacks a natural popular constituency. It is a hard concept to sell voters and cannot easily be translated into campaign "sound bites."

  ---Bureaucratic inertia. Powerful financial or other incentives may often be needed to provide people with a reason to give up some of their turf or shake their regular habits of operation.

  ---Confidentiality. Some believe that programs inability or reluctance to share client information due to confidentiality are a serious barrier to integration. Others believe that this problem can easily be overcome by seeking a generalized permission at the single point of entry.

  ---Benefits of the categorical/specialized system of services. The current categorical system wins political support from clear constituencies which undoubtedly helps protect funding levels in times of economic stringency.

- **Accountability.** There are several challenges in addressing how services integration can be held accountable. First, if the federal government provides greater flexibility to states as to how to spend the federal dollar, taxpayers do need to know how their monies were spent by the

states. Thus, decategorization or block granting should include requirements to report on the program activities in some detail (which several recent block grants have not done).

Second, at the community level especially, when so many systems, agencies, and actors are involved in a collaborative services integration program authority is deliberately, highly diffused. The issue of how conflicts are to be resolved, and who is ultimately responsible for the programs' outcomes are very difficult ones and thus far unstudied though the National Academy of Public Administrators is planning to launch a project to explore this issue (see p. 32).

- **Training and Evaluation.** Training of professional and non-professional staff and how to monitor and evaluate integrated programs are two critical aspects of services reform that have received very little discussion to date. These will be the subject of future seminars/reports.

Policy questions for future discussion

There are dozens of questions that need to be the subject of study and discussion in the future as the service integration movement goes forward. A few that are of most relevance to federal policymakers include:

---What are the costs and benefits of decategorization and block granting?

---Which types of programs/population groups does it make most sense to decategorize/block grant?

---To what extent are services integration initiatives cost effective? How can cost effectiveness be assessed?

---Which integration strategies need extra resources to implement them?

---Will any increased costs be off-set by greater efficiency and program effectiveness?

---Which barriers to services integration can be overcome and how?

PENDING FEDERAL LEGISLATION

While the clear trend in current legislative proposals is to place an emphasis on coordination, providing more flexibility to the states, and funding holistic, integrated approaches to services, two recent proposals with respect to the Alcohol, Drug Abuse and Mental Health Administration move in the opposite direction.

A Senate proposal included in the ADAMHA Reorganization Act of 1991, sponsored by Senator Kennedy, plans to split off the research functions of ADAMHA from the services functions and locate them as three separate Institutes within the National Institutes of Health. At the same time, in the bill reauthorizing the Public Health Service Block Grants in the House, Rep. Waxman is proposing to split the ADAMHA Block grant into two categorical programs, one for substance abuse treatment and services and one for mental health services. National mental health organizations, in general, applaud both developments. It is believed that this "recategorization" will give mental health services a larger share of the funding and increased visibility.

Included below are a selection of the major pending child and family legislative initiatives that include a significant emphasis on some aspect of services integration, coordination, and collaboration.

- **Coordinated Services For Children, Youth, and Families,** Title IX of the Augustus F. Hawkins Human Services Reauthorization Act of 1990. This act, also known as **The Claude Pepper Young Americans Act,** was authorized in 1990 but the sections discussed below did not receive any appropriations. The Senate Appropriations bill currently includes funding for the Federal Council but not for the grants programs.

  Chapter 1 of Title IX establishes the Federal Council on Children, Youth, and Families. One of its functions is to assess Federal activities affecting youth in order to identify duplication of services for young individuals and their families. The Council will make recommendations on the streamlining of services, reducing duplication of services, and encouraging the coordination of services.

  Chapter 2 establishes the Grants for State and Community Programs for Children, Youth, and Families to encourage and assist state and local agencies to coordinate resources and reduce barriers to services. Preference would be given to local service delivery systems that develop systematic collaboration among service providers on behalf of children, youth, and families, including joint planning, joint financing, joint service delivery, common intake and assessment, and other arrangements that reduce barriers to services and promote more effective service systems for such individuals.

  This legislation also establishes Family Resource and Support Program Grants. One section of the grant application requires a description of proposed actions by the state that will reduce practical and regulatory barriers to the provision of comprehensive services to families.

- **Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1991**

  Introduced in the Senate as S. 1306 (Kennedy/Hatch), the ADAMHA Reorganization Act of 1991 was passed by the Senate on August 2, 1991. The House version, H.R. 2803, has seen no action since being referred to the House Committee on Energy and Commerce.

  Title III of the Senate bill, which incorporates the **Children of Substance Abusers Act,** establishes a categorical grants program providing a wide range of services to children of substance abusing parents and to the parents themselves. It requires that the services funded under the grants be accessible, confidential, and coordinated with other relevant services and use service providers from a variety of disciplines.

  Title IV, incorporates the **Children's and Communities Mental Health Systems Improvement Act,** which will provide grants to states for the development of systems of community-based care for children and adolescents. The bill requires collaboration and coordination of services provided by other sections of the bill and with all the relevant federal health agencies and programs and provides for technical assistance to states and localities to improve treatment and coordinate services.

- **The Child Welfare Preventive Services Act (S. 4),** introduced by Senator Bentsen, among other activities, funds demonstration projects in up to 15 states to improve coordination of child and family welfare funding and services. It also orders a review of administrative

policies and regulations in order to improve coordination of funding and service delivery between the federal departments that administer child welfare, AFDC, Medicaid, mental health, education, and juvenile justice systems. The bill has seen no action since it was referred to the Senate Committee on Finance.

- **Families in Need Act of 1991 (S. 1380)**, introduced by Senator Bond, simplifies the eligibility and application process for federal and state-administered programs for women, infants, children, and others by creating a computerized one-stop shopping application process. The bill has seen no action since it was referred to the Senate Committee on Labor and Human Resources.

- **Community Opportunity Act of 1991 (S. 1529)**, which originated as a proposal from the White House Economic Empowerment Task force, was introduced by Senator Hatch. It would provide authority to communities to waive federal statutory and regulatory requirements so that services and benefits for low-income individuals and families funded under categorical or other single or limited purpose federal programs can be integrated and restructured at the community level. It would also provide technical assistance to develop and implement a restructured system for the integrated provision of services and benefits. The bill has seen no action since it was referred to the Senate Committee on Labor and Human Resources.

- **The Link-Up for Learning Demonstration Grant Act (S. 619)**, co-sponsored by Senators Bradley and Kennedy, establishes an Federal Interagency Task Force to facilitate collaboration of support services for at-risk youth at the federal, state, and local level. The bill also funds a demonstration grants program to coordinate and enhance educational and social support services for at-risk youth. The bill has seen no action since being referred to the Senate Committee on Labor and Human Resources.

- **The Comprehensive Services for Children and Youth Act of 1991 (S. 1133)**, introduced by Senator Kennedy, would establish a demonstration grant program in the Department of Education to provide coordinated and comprehensive education, training, health, and social services at a single location to at-risk children and youth and their families. The bill has seen no action since being referred to the Senate Committee on Labor and Human Resources.

- **Resolution to Establish a Joint Committee on the Organization of Congress.** This bi-partisan concurrent resolution introduced on July 31 by Senators Boren and Domenici and Representatives Hamilton and Gradison would establish a joint committee to address comprehensive congressional reform. The rationale for the bill details the problems of multiple overlapping committee jurisdictions leading to fragmented, uncoordinated programs. While the resolution does not detail any specific reforms, the committee would assess an ever-expanding congressional bureaucracy and committee system and inefficient legislative procedures. The committee would be staffed by volunteers.

Other Ongoing Government Initiatives

Ideally we would have liked to include an inventory of current initiatives in the federal government related to services integration, coordination, and collaboration but this was a task beyond our scope. A few of the initiatives that we have come across have been mentioned in the body of this report. Several others have not.

Two such examples in the executive branch are:

- **A joint DHHS/DOT Coordinating Council on Human Service Transportation.** Launched in 1986, its main objective is to promote the coordination of federal policies, regulations, and resources targeted on the provision of specialized human service transportation. In practical terms one of the issues this Council is working on is whether programs for the elderly and handicapped could share the use of public buses.

- **A Study Group on Service Integration for At Risk Youth and Families** was set up under a Memorandum of Agreement established between the Departments of Education and Health and Human Services. The purpose of the group is to develop a reference **guide** for communities wishing to provide school-linked services for students and their families.

And on the congressional side:

- The **General Accounting Office,** Human Resources Division, is undertaking at the request of Senator Christopher Dodd a study of service improvement. GAO has chosen to examine three models of improving services for disadvantaged children and families and is examining Head Start, the system reform initiatives in North Dakota, Maryland, and Connecticut, and state experience with P.L. 99-457 (contact: Dave Bellis). A second, related study requested by Senator Edward Kennedy, addresses the delivery of comprehensive services in schools, (contact Bill Schmitt) and a third will examine coordination and duplication of services in the largest health programs (contact Audrey Clayton).

- The **Congressional Research Service,** Education and Labor Division is working on an overview concept paper on the coordination of children's programs (contact Ruth Wassem).

ORGANIZATIONS WITH A MAJOR INTEREST IN SERVICES INTEGRATION, COLLABORATION & COORDINATION

(Note: Private Foundations with a major interest in this issue include: Annie E. Casey Foundation, Kaiser Family Foundation, and Pew Memorial Trust.)

American Enterprise Institute/White House Working Seminar on Integrated Services

With the collaboration of the White House and funding from several private foundations,in the summer of 1991 the American Enterprise Institute launched a 24 month project called, the Working Seminar on Integrated Services for Children and Families. Members of this approximately 35 person seminar include high level government officials from six departments, members of Congress, prominent scholars, and others. The Seminar will meet several times over the course of the year. The purpose of the project is to examine the strengths and weaknesses of the current categorical social welfare system and possibilities for services integration. Based on the work of the seminar discussions the final report will present recommendations for legislative and administrative reform.

Contact: Douglas Besharov, American Enterprise Institute, 1150 17th Street N.W., Washington, D.C. 20036. 202-862-5800.

Association for the Care of Children's Health (ACCH)

The Association for the Care of Children's Health is an educational and advocacy organization with a multi-disciplinary membership, representing health and social service professionals, educators, researchers, parents, and community leaders. ACCH members work within their own institutions, organizations, and communities to promote improved, coordinated systems of health care for children and their families.

ACCH's activities include producing and publishing many educational materials and projects promoting greater understanding of family-centered care such as: a pediatric AIDS project, a national Information Clearinghouse for infants with disabilities and life threatening conditions, and promoting parent support groups.

Contact: Beverly Johnson, ACCH, 7910 Woodmont Avenue, Suite 300, Bethesda, MD 20814 301-654-6549.

Center for the Study of Social Policy

The Center, established in 1979, is a non-profit research and study organization whose current activities include a major focus on improving child welfare systems in the states and, most recently, in the District of Columbia. The Center conducts a number of activities related to promoting family preservation including maintaining a clearinghouse of information on state and local family preservation projects, development of a series of working papers, and providing technical assistance to states on how to develop, finance, and administer family preservation programs.

The Center serves as a research and evaluation resource to the Annie E. Casey Foundation's New Futures program, a collaborative effort to reform services for youth at risk in four sites and to its statewide child welfare services reform projects in Maryland, Connecticut, Iowa, and North

statewide child welfare services reform projects in Maryland, Connecticut, Iowa, and North Dakota. The Center is also the publisher of KIDS Count, a state by state data book on indicators of child wellbeing and will assist eight states to produce their own state-based KIDS Count indicators.

Contact: Frank Farrow, CSSP, 1250 Eye St. NW, Washington, DC, 20005. 202-371-1565.

Council of Chief State School Officers (CCSSO)

The Council of Chief State School Officers is a nationwide, non-profit organization comprised of the 57 public officials who head the departments of elementary and secondary education in the fifty states, the District of Columbia, five U.S. extra-state jurisdictions, and the Department of Defense Dependent Schools. The Council provides professional development opportunities for its members on issues of current state concern and conducts various research and resource activities. The Council's Resource Center on Educational Equity was established to provide services designed to achieve equity in education for minorities, women, and girls and for disabled, limited English proficient, and low-income students.

The Council advocates the involvement of its membership in state level strategies to facilitate collaboration and the delivery of comprehensive services. CCSSO is a partner with the American Public Welfare Association in the operation of the Joining Forces program. In the coming year the Council plans to work with other organizations to examine the legislative and regulatory barriers at federal and state levels towards achieving the goals of compensatory education programs (Chapter 1), special education, and bi-lingual education with the goal of making recommendations about possible decategorization.

Contact: Cynthia Brown, Resource Center on Educational Equity, CCSSO, 400 North Capitol Street, Suite 379, Washington, DC 20001. 202-393-8161.

Education and Human Services Consortium

The Education and Human Services Consortium is a loosely knit coalition of national organizations concerned with interagency efforts to connect children and families with comprehensive services. It uses its capacity to distribute materials to large cross-sector audiences to generate discussion and constructive action on collaboration at the local level. With funding from a number of foundations the Consortium has printed and distributes over 85,000 copies of three monographs to date.

Contact: Martin Blank, Institute for Educational Leadership, 1001 Connecticut Ave. NW, Suite 310, Washington, DC 20036. 202-822-8405. Or Atelia Melaville, W.T. Grant Commission Foundation, 1001 Connecticut Ave, NW, Suite 301, Washington, DC 20036. 202-775-9731.

Institute for Educational Leadership

The Institute for Educational Leadership (IEL), is an independent, non-profit organization, which convenes key individuals and organizations across sectors, conducts policy studies, and works to develop leaders, at all levels, with the skills needed to collaborate. Its efforts include jointly sponsoring the National Health/Education Consortium and the Education and Human Services Consortium.

IEL has recently launched two leadership programs for collaboration. The Collaborative Leadership Development Program is designed to enable elected and appointed lay and professional leaders of local institutions and agencies to develop the skills needed to function in a more collaborative manner, and a second initiative focuses on helping mid-level agency personnel in education and other sectors.

Contact: Martin Blank, IEL, 1001 Connecticut Ave, NW, Washington, DC 20036. 202-822-8405.

Joining Forces

Joining Forces is a joint initiative of the Chief State School Officers and the American Public Welfare Association. It seeks to promote and assist collaboration among the education, welfare, and child welfare systems to 1) help disadvantaged and high-risk families better support their children's education; 2) help schools improve the academic achievement of children at risk; and 3) help schools assure that individuals of all ages have access to and are supported in obtaining appropriate services.

Contact: Janet Levy, 400 North Capitol St. NW, Suite 379, Washington, DC 20001. 202-393-8161.

National Academy of Public Administration (NAPA)

The National Academy of Public Administration is a nonpartisan, non-profit organization of elected Fellows established to improve the effectiveness of government at all levels. Formed in 1967, the Academy conducts studies and provides counsel on public management issues and the practical implications of public policy. Among its major current priorities are (a) improving the competence and quality of the public service sector; (b) strengthening the nation's ability to set goals, ensure effective execution, and measure public performance; and (c) making federalism work.

The Academy conducts studies and seminars, provides scholarships and awards, and has a program of publications. NAPA is in the process of examining accountability questions arising from the management and implementation of new services integration efforts at the local level.

Contact: Brett Hammond or Don Wortman, NAPA 1120 G St., NW, Suite 850, Washington, DC 20005. 202-347-3190

National Commission for Employment Policy (NCEP)

The National Commission for Employment Policy is an independent agency established under Title IV (f) of the Job Training Partnership Act, formerly known as the Manpower Policy Commission. It is charged with making recommendations to the President and Congress on national employment and training issues and, *inter alia*, assessing the extent to which public assistance policies represent a consistent, integrated, and coordinated approach in meeting the nation's employment goals and needs. The Commission's 15 Members are appointed to these voluntary positions by the President while they serve as business and labor leaders, human resource professionals, and state and local elected officials.

In 1990, the Commission launched a project to focus on Improving Coordination in Government Sponsored Public Assistance Programs. Under this project the Commission held three large seminars in Washington, DC, San Antonio, TX, and San Diego, CA; conducted hearings across the country; and commissioned numerous papers focusing on federal, state, and local issues of coordination.

In early October, the Commission issued its recommendations to the President and the Congress in the form of letters to the President and the Congressional leadership. A Commission report containing the recommendation letters and some background material will be published later in 1991. Plans are underway to publish a volume of the commissioned papers to be available in 1992. (See Jennings & Zank, 1992; Zank, 1991.)

Contact: Neal Zank, Associate Director, NCEP, 1522 K St. NW, Suite 380, Washington, DC 20005. 202-724-1553.

National Health/Education Consortium

Founded on the assumption that "children must be healthy in order to learn and they must be educated to keep themselves healthy" the Consortium is promoting a variety of joint collaborative activities designed to stimulate integration between health and education. The Consortium will identify and disseminate model initiatives, convene conferences and meetings to promote dialogue, provide a roster of speakers, and issue publications. The Consortium involves leaders from 41 health and education organizations. It was convened by the Institute for Educational Leadership and the National Commission to Prevent Infant Mortality.

Contact: Michael Usdan, Institute for Educational Leadership, 1001 Connecticut Ave. NW, Suite 310, Washington, DC 20036. 202-822-8405. Or Rae Grad, National Commission to Prevent Infant Mortality, Switzer Building, Rm. 2014, 330 C St. SW, Washington, DC 20201. 202-472-1364.

National Maternal and Child Health Resource Center/National Resouce Center on Community-Based Service Systems

The National Maternal and Child Health Resource Center's mission is to improve the health and related services for mothers and children including children with special health care needs. Its activities include maintaining an information clearinghouse and conducting a number of interdisciplinary research studies and special projects with a special emphasis on public policy. The Resource Center staff provide technical assistance, training, and consultation upon request.

The Resource Center has as its primary focus the development of community systems of comprehensive, coordinated family-centered services for children; including, but not limited to, children with special health care needs and their families.

Contact: Josephine Gittler, NMCHRC, College of Law Building, University of Iowa, Iowa City, Iowa 52242. 319-335-9067

National Resource Center for Community-Based Service Integration

Mathtech, Inc., a private consulting firm, is the manager of a consortium of organizations which will collectively operate a new National Resource Center for Community-Based Service Integration. The Resource Center will synthesize past lessons in SI, serve as a clearinghouse of information, provide technical assistance in the development and operations of integrated service delivery systems, and foster the development of local efforts through convening meetings and assisting with the formation of a network of leaders and advocates of SI. Included in the consortium are the National Center for Children in Poverty, Columbia University, the National Governors' Association, the Child and Family Policy Center in Iowa, Policy Studies Associates, Inc., Sarah Shuptrine and Associates, and the California Research Institute. The Center is funded under a grant from ASPE/DHHS.

Contact: William Morrill, Mathtech, Inc., 210 Carnegie Center, Suite 200, Princeton, NJ, O8540. 609-520-3885. Or Richard Silva, Office of the Assistant Secretary for Planning and Evaluation/DHHS, 200 Independence Ave. SW, Rm 410 E, Washington, DC 20201. 202-245-7507.

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